icmif

भारतीय बीमा संस्थान
INSURANCE INSTITUTE OF INDIA

5-5-5

The missing chapter of microinsurance in India: a diagnostic of mutuals

ICMIF country diagnostic on mutual and cooperative microinsurance in India

July 2017

The International Cooperative and Mutual Insurance Federation (ICMIF) in association with the Insurance Institute of India (III)

ACKNOWLEDGEMENTS

Case study organizations
Uplift Mutuals
DHAN Foundation
The Goat Trust
VimoSEWA
Society for Elimination of Rural Poverty (SERP)
ESAF Swasraya Multi State Cooperative Credit Society Limited
Calcutta Hospital & Nursing Home Benefits Association Limited (CHNHBA)

Research team
Dr George E. Thomas, Professor, College of Insurance, Insurance Institute of India (III)
Professor Archana Vaze, Assistant Professor, College of Insurance, Insurance Institute of India (III)
Arman Oza, Freelance Consultant and past CEO of VimoSEWA
Dr Shariq Nisar, Islamic Finance Expert

Research coordinator
Kumar Shailabh, Executive Director, Uplift Development Solutions and Services (UDSS)

ICMIF
Professor Thankom Arun, Chair of the ICMIF Academic Steering Committee on Financial Inclusion (ASC)
Sabbir Patel, ICMIF
Payal Agarwal, ICMIF

FOREWORD

Professor Thankom Arun

It is quite evident that the inability to manage risks increases the vulnerability of both individuals and communities, thus affecting the resilience within communities against disasters. The World Development Report 2014[1] clearly illustrates that effective risk management can be a powerful instrument for development, and calls for structural policy measures, community-based prevention, insurance, education, training, and effective regulation. Microinsurance is now accepted as an integral tool for poverty alleviation and building resilience. Mutual microinsurance encompasses all types of low-income groups which may not fall under the conventional definitions of microinsurance. Moreover, mutual, cooperative and other community-based organizations (MCCOs) have the ability to align the incentives of both the insurer and the insured, and to provide lower cost security against the common risks among all income groups in a society, rendering the mutual approach distinct.

Globally the International Cooperative and Mutual Insurance Federation (ICMIF) represents the interests of over 290 "people-centered insurers" in 75 plus countries, and in 2015 adopted the 5-5-5 Mutual Microinsurance Strategy to develop mutual insurance in emerging markets. This ambitious Strategy plans to develop mutual microinsurance programs in five emerging markets (Colombia, Kenya, India, the Philippines, and Sri Lanka), reaching out to 5 million new households over a five year period. ICMIF has also formed an Academic Steering Committee (ASC) to oversee the research element of the project. The 5-5-5 Strategy demonstrates the commitment to help improve the resilience of poor people to disasters and to the United Nations 2030 Sustainable Development Goals (SDGs).

We are pleased to present the ICMIF country diagnostic study on mutual and cooperative microinsurance in India. ICMIF partnered with the Insurance Institute of India (III) to undertake this study, along with its member organization, Uplift Development Solutions and Services. The study clearly reveals the distinct Alternative Risk Management (ARM) model of MCCOs which exists, primarily catering to the low-income population. In India, there are 15 mutuals and cooperatives, across 13 States, providing insurance services to approximately 1 million people using risk retention or risk sharing models. However, the time has indeed come for the regulators to identify the relevance of this model, and develop appropriate supporting structures and policies for MCCOs in order to scale-up and be sustainable. As this report underscores, the value-based and needs driven approach of MCCOs will have a productive future in India.

Professor Thankom Arun
Chair of the ICMIF Academic Steering Group on Financial Inclusion (ASC)

[1] World Development Report 2014: Risk and Opportunity: Managing Risk for Development World Bank 2014

CONTENTS

KEY TAKEAWAYS AND FINDINGS

Mutual and cooperative models of insurance have shown remarkable growth in recent years, and commanded a global market share of 27% and a premium income of USD 1.3 trillion in 2014. Mutual, cooperative and other community-based organizations (MCCOs)[2] (also referred to as "mutuals") provide insurance services to 955 million people around the world, either as members or policyholders, and directly employ 1.1 million people[3]. However, in many emerging markets, the potential of mutual insurance has not been tapped and the sector is underdeveloped. Thus, **in January 2015, the Development Committee of the International Cooperative and Mutual Insurance Federation (ICMIF) adopted a first-of-its-kind initiative led by the mutual insurance industry to provide insurance for low-income groups, ie the ICMIF *5-5-5 Mutual Microinsurance Strategy*.** Under this *Strategy*, ICMIF along with its member organizations, seeks to provide mutual microinsurance solutions to 5 million previously uninsured low-income families, (25 million poor individuals), in five countries in emerging markets over the next five years.

India is one of the five emerging market countries selected by ICMIF for the development of MCCOs given its huge uninsured population, emphasis on microinsurance, and strong on-the-ground presence of ICMIF members within the country. This country diagnostic study is the first of three stages to implement the *5-5-5 Strategy*, the other two stages being the creation of an evidence-based country strategy based on the country diagnostic, and lastly the implementation of the country strategy through a country intervention program.

In India, ICMIF partnered with the Insurance Institute of India (III) to undertake the country diagnostic along with its member organization Uplift Development Solutions and Services. The study attempts to present the landscape of MCCOs in India including their market potential and challenges, and suggests ways to create an enabling environment for their growth and development.

Defining MCCOs in the Indian context

The study took note that in the absence of clear regulatory definitions and variations in the organizational and operative models of different MCCOs (especially among the minor ones) in the country, it would be imperative to define MCCOs on prudential lines. This would ensure that the values enshrined in the IAIS (International Association of Insurance Supervisors) and ICMIF philosophies of mutuality, community focus and good governance are not diluted.

As per this study, ***an MCCO, in the Indian context (or elsewhere) should be founded on mutuality and have a strong mutual ethos. Its organizational structure and insurance-like operations should be for the protection needs of the marginalized population which forms the bulk of its membership. It should be community-owned and be governed, owned and run with member participation. It should have regular engagement with its members and designed for long-term financial sustainability.***

This definition was evolved from various literature reviews including ICMIF literature and used by the authors to carry out the study. This was confirmed on-the-ground during the study as well.

[2] Mutuals, cooperatives and other community-based organizations (MCCOs) and their functioning are discussed elaborately by the IAIS in its papers titled Issues in regulation and supervision of microinsurance (June 2007) and Issue paper on the regulation and supervision of Mutuals, Cooperatives and other Community-based Organizations (October 2010). Discussed in more detail under Annexure B

[3] ICMIF Global Mutual Market Share 2014, ICMIF, 2016

Takeaway 1: A distinct Alternative Risk Management (ARM) model of MCCOs primarily catering to the low-income population has evolved and exists in the country.

The study reveals that MCCOs have different risk management mechanisms in place to protect their members, and are practicing certain interventions for risk reduction control. While some do use the risk transfer mechanism of insurance, there is a distinct ARM model without risk transfer (based on the principle of risk retention) practiced by MCCOs, which caters to the risk mitigation needs of the lower and non-mainstreamed strata of society, using principles akin to the insurance mechanism roughly on the patterns indicated by the IAIS.

Evidence of the efficacy and potential of this model in India has been documented in various studies conducted by different national and international agencies.

There are 15 mutuals and cooperatives, across 13 States, providing insurance services to approximately 1 million people using risk retention or risk sharing models.

Risk transfer, risk retention and Alternative Risk Management*

Risk is naturally borne or retained by an individual entity, or a natural group such as a family, extended family or community. Risk is also retained by bodies like Protection and Indemnity (P&I) Clubs, risk retention groups or similar groups. The risk is transferred outside this affinity group to another entity (the insurance company) through the insurance mechanism.

While risk is retained under the mutual model by MCCOs, in the commercial insurance model the risk gets transferred to insurance companies.

It was observed that the MCCOs provide solutions (such as health education, negotiated rates and services in affordable hospitals, help in coping up after loss/bereavement, physical nursing care during hospitalization, advance payment of expenses, funeral support etc), which transcend the typical realm of commercial microinsurance. Hence, the services provided by MCCOs including those similar to insurance services are referred to as Alternative Risk Management (ARM).

(*For the purpose of this study)

Takeaway 2: These MCCOs are building an inclusive, bottoms-up risk reduction model where low-income families get a say in the design and delivery of insurance services.

Low-income families (who otherwise are mostly treated as beneficiaries) are engaged in the design and delivery of insurance-like services with a clear focus on risk reduction. Over 90% of the policyholders of MCCOs are women, making them at par with other financial inclusion products. They design insurance products and services that are unavailable in the market and focus on making the claims process easy and transparent. MCCOs invest about 20% of their resources in insurance education and awareness and also have robust grievance redressal systems. These MCCOs may not have the desired scale but have been able to show clear impact in protecting the lives and livelihoods of the poor by bringing insurance services to those who previously didn't have access to them.

Takeaway 3: The potential for developing MCCOs is huge in India.

With about 600,000 cooperatives in the country and a membership of over 250 million, the potential for developing mutual and cooperative insurance in India is enormous, though fraught with multiple challenges. Mutual and cooperatives allow low-income families to participate in the design and delivery of such products and services and can become the foremost model of financial inclusion. To realize this potential, it is important that a regulatory regime conducive to development is in place, which can delicately balance the solvency requirements of risk carriers with the risks of covering the lives and livelihoods of the poor in a realistic manner.

Takeaway 4: MCCOs need support to scale-up and be sustainable.

Most MCCOs need financial support in the form of capital infusion by way of soft loans, corporate social responsibility (CSR) funds, reinsurance or access to capital markets. They require assistance to organize themselves as an association or guild to enable collective and concerted action. Support, in the form of knowledge and skills, in the areas of fund management, actuarial science, risk evaluation, risk management, underwriting and claim settlement could also empower MCCOs. The use of actuarial science and long-term probability studies, information technology support and data management systems are vital ingredients of modern day governance and risk management systems.

Takeaway 5: The time has come for the Government/regulator to recognize this model if not regulate it; self-regulation could be a viable alternative.

The Government should realize that MCCOs and the ARM models that they operate have come of age and have outgrown the developmental stage when "benign neglect" was warranted. These need to be regulated or at least legally recognized.

Appreciating the practical difficulties faced by the regulators in regulating multiple small organizations, the study recommends creating broad models of self-regulatory organizations (SROs) with robust governance systems, accountability to the communities that they represent, and responsibility to the society and the Government at large.

Taking advocacy as one of the logical outcomes of the study, the presence of robust internal governance mechanisms would assist the advocates in taking up the case more effectively with the governmental/regulatory agencies. International organizations like ICMIF can bring internationally accepted best practices into the country.

Most MCCOs expressed their wish to be allowed to operate preferably as Insurance Regulatory and Development Authority of India (IRDAI) licensed entities or at least as "IRDAI Recognized Mutuals"/"IRDAI Recognized Cooperatives". Only those willing to operate as per a specific regulatory framework may be licensed/ recognized. Creation of macro level supervisory norms for sustainable low capital models would entail creating prudential checks, including:

- caps on sum insured;
- defining customer segments;
- defining products/product lines;
- linking exposure to entity level capacity;
- creating risk retention parameters with provision for reinsurance;
- insisting on efficient governance systems and macro level safeguards that conform to international best practices;
- insisting on transparency to all stakeholders;
- insurance being a distinguishable major vertical; and
- participatory contribution by members is indispensable.
- In addition to participatory contribution, allowing supplementary financing mechanisms including sponsored activities by insurers, who might use these models to develop new markets later on (eg DHAN Foundation's rain gauge initiatives proved to commercial insurers that small rural farmers were also insurable).

Takeaway 6: MCCOs and commercial insurers can collaborate to provide efficient risk management to the low-income population.

MCCOs should be allowed to take reinsurance capacity where required from commercial insurers. Such support may be treated as compliance to the Rural and Social Obligations (RSOs) of the insurer. As coinsurance does not follow the philosophy of risk retention and the community focus, core to the MCCO model, the same is not recommended. This would also provide for indirect operational supervision by making reinsurance mandatory above specific thresholds of risk exposure, in terms of numbers and/or amounts. Another solution would be creating a specific company (or a pool/wing under the national reinsurer) which would provide insurance cover to MCCOs and all the rural and microinsurance programs in the country, covering life, credit, cattle, crop, poultry, agricultural pumps, beehives, bicycles, agricultural implements etc.

Takeaway 7: On the basis of the country diagnostic, three broad action points have been identified at the macro, meso and micro level to help develop MCCOs in India.

Figure 1: Three recommendations from the country diagnostic:

Macro level: Advocacy for MCCOs

Advocate for specific enabling legislation leading to recognition (if not regulation) of MCCOs as a viable ARM mechanism for achieving inclusive growth.

Meso level: Organizing MCCOs

Organize MCCOs under international forums, such as ICMIF. As policymakers may not be aware of the model and the parties involved many not have the capacity to secure their rights, there is a strong case for external support by way of advocacy and providing proof of concept.

Micro level: Creating evidence on the ground

Support existing MCCOs with scaling up through financial and technical support, and help establish new MCCOs to demonstrate proof of concept.

SECTION I: SETTING THE CONTEXT

In India, mutual insurance is not widely known despite the fact that there were mutual insurance companies in existence even before the country's independence in 1947. Although there were subsisting provisions under the Insurance Act of 1938 and a health insurance mutual was specifically exempted from nationalization by the General Insurance Business Nationalization Act (GIBNA) of 1972, post-independence no specific enactment was made for mutual or cooperative insurance. In 2002, in an amendment to the Insurance Act of India 1938, there was a brief mention of cooperative and mutual insurance.

In the absence of regulations for mutual or cooperative insurance in India, ICMIF was aware of the difficulty in conducting such a diagnostic, though some of its members have well known programs. ICMIF was also aware of the dearth of available literature on the mutuality aspects of community-based and mutual schemes in India. Lack of regulations has meant that there would be a lack of industry wide data on MCCOs. Barring a handful of case studies, literature is mostly silent on the outreach and impact of MCCOs. In the absence of information, it becomes difficult to identify the bottlenecks that impede the growth of the mutual model or formulate a strategy for technical assistance and advocacy. ICMIF took into account the fact that industry-wide data and evidence-based success stories of MCCOs are essential to create a rightful space for the mutual model in these emerging markets.

In this context, ICMIF partnered with the Insurance Institute of India (III) to do a first-of-its-kind diagnostic (study) focused on the mutual model in India. Earlier studies have focused on particular aspects of community-based microinsurance in India. However, there has been no prior study to understand the country landscape with regard to MCCOs, and the models of their operations in India and the extent they abide by mutual and cooperative values.

Based on the country diagnostic design, the country study was carried out in two parts; the landscape of MCCOs, and case studies of select models.

- The aim of the **landscape section** was to provide a comprehensive picture of MCCOs and the models operated by them by identifying as many players and schemes as possible.

- The **case studies section** aimed to document prominent MCCOs in India, highlight their products, business models, best practices, challenges in risk coping and other key concerns. A set of common parameters were developed for the case studies, so that they would be comparable across the five countries. Data found against these common parameters would help in identifying potential patterns of success. Based on this analysis, the country diagnostic will identify the challenges facing the mutual model, and make recommendations for future development.

Research approach and methodology

The country diagnostic study was conducted with a "three-pronged" methodology, including; secondary desk-research, primary data compiled through questionnaires to practitioners complemented by telephone interviews and field visits to document case studies, and beneficiary feedback through focus group discussions (FGDs).

Secondary research data collection includes the country context, Government policy on financial inclusion, social microinsurance schemes, existence and coverage of cooperatives, relevant regulations, and mutuals. A host of sources such as prior studies, web portals of mutuals, journal articles, blogs and unpublished material were used for secondary research.

The study relied largely on primary research as there is no database of MCCOs in India. Information on the geographical spread of mutuals, their outreach, products and services offered has been collected. A mix of the qualitative and quantitative research approaches were used to collect primary data.

A list of 45 known mutual and cooperatives was sourced from various publications and knowledge of the team members, and a communications plan was drawn to contact these organizations for telephonic interviews.

A letter of introduction and a survey questionnaire was sent to all of those where contact could be made. A request for information was shared on LinkedIn and UN Solution Exchange, which is a known platform for discussing development issues in India.

However, contact could be established with only 24 of the 45 organizations, and survey interviews could be conducted only with 18 organizations. Of these 18, **only 13 had mutual-related data and were forthcoming with relevant information or figures.**

Structured questionnaires were used to conduct a survey amongst MCCOs. The questionnaire was distributed to all MCCOs, and the following information was gathered:

- Legal form and nature of the organization.
- Products and services offered, and outreach (geography and policyholders).
- Governance of the scheme.
- Client education and grievance redressal mechanisms.
- Use of technology.
- Major performance ratios.
- Opportunities and challenges faced.

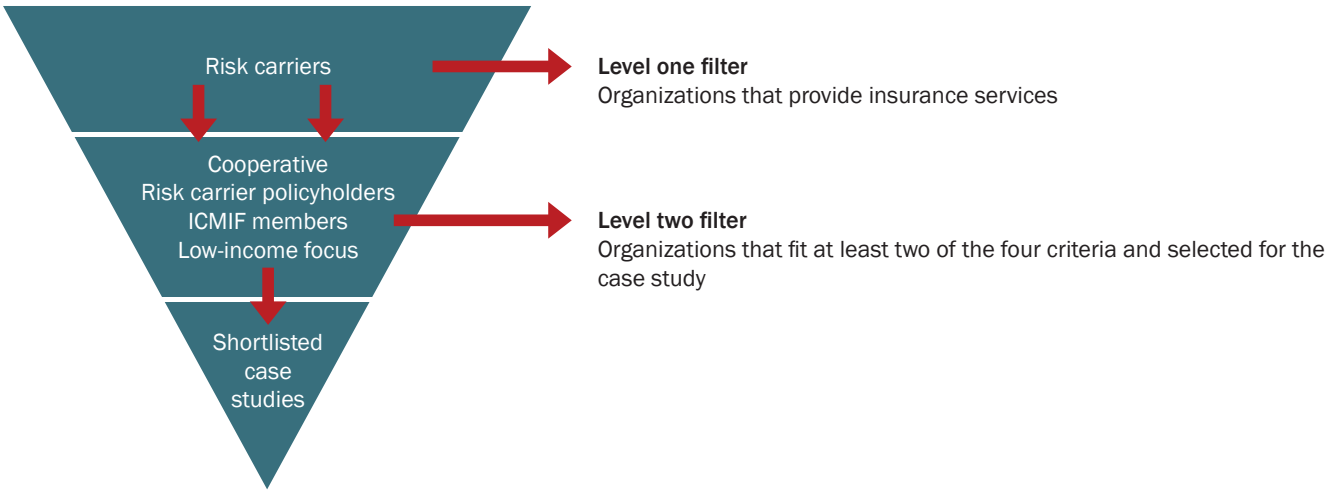
These questionnaires were distributed electronically and telephone follow-ups were conducted to solicit a prompt response, resolve queries on the questionnaire and ensure confidentiality of data.

Qualitative data was collected to supplement the findings of the survey questionnaire and to develop in-depth insights into the drivers and challenges faced by MCCOs. Key informant interviews were conducted with the management and field teams of mutuals. The key informant interviews included discussions on:

- Understanding the demand for ARM services in terms of customer profile, usage and demand of products;
- Risks faced and coping mechanisms used by the target population;
- The extent of risk coverage provided by ARM products;
- Financial risk management;
- Level of community involvement in governance of the mutual;
- Members' satisfaction;
- Potential gaps and factors impacting growth/outreach; and
- Impact (if possible, and recorded by the mutual).

Case studies: The country diagnostic also adopted a case study approach to showcase and highlight the work of selected MCCOs. The purpose of the case studies was primarily to showcase the different types of mutual and cooperative models in India and their impact on reducing the vulnerabilities of the poor, identify their needs for technical assistance and drawing insights into factors inhibiting their growth. The most important criterion was whether the organizations are MCCOs providing ARM services by retaining risk, have retained risk in the past, or intend to do so in the future. Organizations that have moved on to become insurance companies entirely or partly (in cases where only some communities moved) as insured groups or converted themselves as partner-agents were also considered.

Figure 2: Selection of case studies – application of the parameters



Although it may seem obvious, these criteria have been used as a "gate-keeper" to ensure that only organizations that provide ARM services are selected for the case study. This is because there are many organizations in India that provide pre-paid healthcare services which are often mistaken as microinsurance. Moreover, there are some large scale successful Government social security schemes for the poor which also may not strictly qualify as insurance but do help the poor in managing their risks.

Once the boundary has been established by applying the criteria on ARM, a second set of criteria were applied to select the case studies. The MCCO would have to qualify for a minimum of two out of the four criteria given below:

ICMIF membership: The organization should be a current ICMIF member. This ensures that the organization is either an MCCO or has its roots in the cooperative and mutual philosophy (such as IFFCO-TOKIO General Insurance Company in India).

Low-income focus: The IRDAI definition of microinsurance products, ie policies with a sum assured of less than INR 50,000 (around USD 750)[4] was adopted to determine the low-income focus. Hence, this study set a criterion that to qualify under this category about 50% of the portfolio of an MCCO should comprise of policies with a sum assured of INR 50,000 (around USD 750) or less.

Legal entity: Since the mutual space is not regulated by the IRDAI and there being no specific legal forms prescribed for MCCOs, many do register as cooperatives. Hence, the study fixed a criterion that the MCCO should be registered as a cooperative, as it provides for policyholders' ownership, or as any other legal entity under Indian Law with the concept of collective ownership and mutuality built into its governance.

[4] At exchange rate of USD 1 = INR 65. This exchange rate is used throughout the report

Risk carrier: The risk is not transferred to a third party; and is therefore carried by the policyholders themselves.

Each case study included a study of the business model of the insurer, geographical coverage, products and services offered, social presence, impact on the lives of the target group and future plans for scale. FGDs were conducted with the staff and the policyholders to understand operational issues and the impact of microinsurance respectively. Key informant interviews were conducted with the management team to get insights into the business model, drivers of growth and operational challenges faced. A couple of organizations with the potential and willingness to start mutual microinsurance were also studied. In all, about seven case studies were conducted as part of the diagnostic.

Limitations of the study

The study has relied primarily on **self-reported data** from mutual and cooperative micro-risk retainers. As a result, it may suffer from the biases of self-reported data, which could include the following:

Selective memory: During the surveys and key informant interviews, it is possible that some respondents might have forgotten or missed crucial data points such as problems faced during product design and roll-out, technical assistance/inputs that were crucial to the success of the program or some crucial aspect of the client profile.

Overstatement or understatement: MCCOs might have overstated or understated their outreach and impact of their initiatives and the role they have played in coping with risks.

Limited access to information: Some MCCOs might have been reluctant to share full and accurate data on certain aspects of information such as number of persons covered, premium amount, claims ratio, external funding, or any other aspect that might reflect poorly on their initiatives or fear of regulatory awareness.

Time constraints: There might have been a time constraint as the study needed to be completed within the stipulated time period and it was not feasible to wait for all MCCOs to share the data asked for.

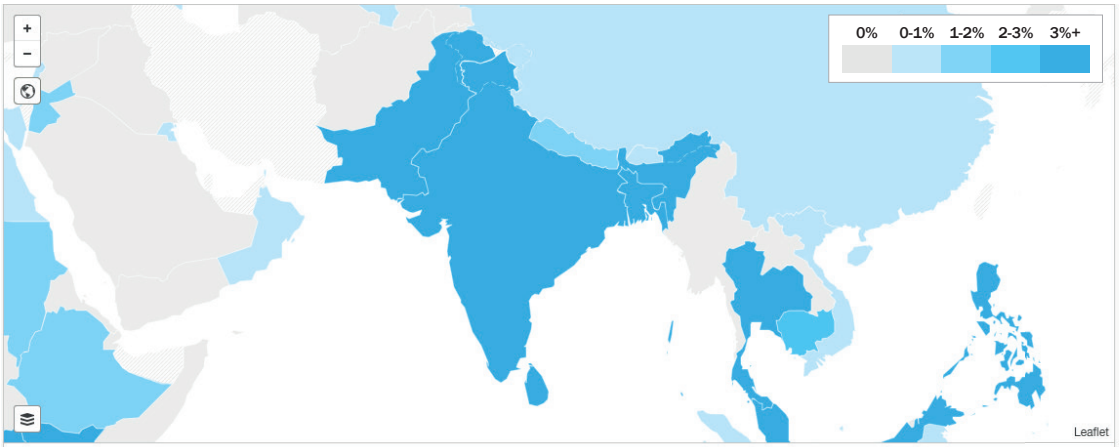
Incomplete data: As small entities, many of the MCCOs did not have segregated data on different products and services, or a clear view on the regulatory changes required. Thus, even when the organization was willing to provide information, the requisite data was not readily available.

Lack of prior research and database: The unavailability of prior research or a database on MCCOs has made the scope of the study exploratory in nature. As a result, the researchers had to start by compiling a list of the players in the MCCO space and then understand their characteristics and their constraints.

SECTION II: CONTEXTUALIZING 10 YEARS OF MICROINSURANCE IN INDIA

The IRDAI guidelines of 2002 on the "rural and social obligations of insurance companies" acted as a catalyst in the development of the microinsurance sector in India. The Microinsurance Regulation of 2005 gave further boost to the microinsurance sector. Since the regulatory push for microinsurance by the IRDAI, the last decade has seen a significant growth in the microinsurance sector in India. India leads the microinsurance coverage in Asia with over 422 million lives and properties reported covered under various voluntary and social microinsurance schemes. For the period 2010-2012, microinsurance in India witnessed an annual growth rate of 30% and accounted for almost 70% of the growth in voluntary microinsurance in Asia[5].

Figure 3: Status of voluntary microinsurance in India, 2012



India

Population (2012)	GDP per capita (2012)	Microinsurance Premiums (2012)
1,236,686,732	1,504$ (US)	544,900,000$ (US)

9.22% Total microinsurance coverage ratio	**4.72%** Accident coverage ratio	**3.89%** Life coverage ratio (excluding credit life)	**1.78%** Agriculture coverage ratio
1.26% Health coverage ratio	**0.39%** Property coverage ratio		

Status of voluntary microinsurance in India, 2012, 111.1 million lives covered (does not include social insurance or informal schemes)[6]

This increase could be largely attributed to high economic growth and a rise in disposable income amongst the low-income households, a forward-looking insurance industry, proactive civil society and a mature microfinance industry. Alternative distribution channels, use of technology and innovative enrolment and claims processes have enabled cost-efficient scaling-up and servicing of microinsurance programs. Central and State Governments have launched ambitious social security and health benefit insurance schemes that have led the growth of microinsurance in India. Almost all microfinance institutions (MFIs) offer credit life and credit life plus covers.

[5] The Landscape of Microinsurance in Asia and Oceania – Briefing Note GIZ and Munich Re, 2013
[6] Reproduced courtesy of http://worldmapofmicroinsurance.org/#country/IND

Table 1: Social microinsurance schemes in India with more than 10 million lives covered[7]

Scheme	Risk	Individuals covered (in millions)
Rashtriya Swasth Bima Yojana	Health	130.5
Rajiv Arogyashree Yojana	Health	89.6
Chief Minister's Comprehensive Health Insurance Scheme (earlier Dr Kalaingar)	Health	54.4
Aam Aadmi Bima Yojana	Life	20.3
National Agriculture Insurance Scheme	Agriculture	16.3
Total		311.1

Amidst this action, **three distinct models of microinsurance have emerged at the sector level.**[8]

The **compulsory model** emerged out of a "piggybacking" of insurance with a fast moving microcredit product. Mainly credit life and index-based weather insurance products are offered under this model. Since the primary aim of this model is to reduce the credit risk of the MFI or bank, the benefits of insurance are not quite felt by the borrowers therefore such products often have a low client value. To some extent, this also happens on account of lack of transparency and education.

In order to overcome this criticism, many MFIs started offering "credit life plus" policies where a part of the benefit also accrues to the nominee of the deceased borrower. Despite its limitations, recognition for supplying insurance to a large number of people can be given to this model. It has provided a good firsthand experience of insurance to many poor households.

However, the compulsory model's dependence on microcredit outreach limits its potential to the credit clientele. This model will eventually reach its culmination once microcredit markets start approaching their saturation levels. The fact however remains that this model currently commands a sizable share in the microinsurance market.[9]

The active involvement of governments in the social security space of the world's emerging markets has given birth to the **subsidized model**. Again this model comprises mainly of term life, health and agriculture insurance covers offered to the ultra-poor households.

A substantial part of the premium (if not the full) is subsidized by the Government. Because of this very character, the subsidized model has succeeded in attaining sizable outreach in a short span of time. Huge and quick volumes also come with their due share of problems at the service delivery level.

Lack of information and facilitation at the ground level and absence of effective monitoring mechanisms are some of the challenges the subsidized model is grappling with. It will be a while before such schemes settle down and demonstrate tangible impact on the risk profile of the target population. Moreover, the fundamental questions concerning the macro-economic suitability and financing plans of these schemes, and their long-term sustainability also remain.[10]

[7] The Landscape of Microinsurance in Asia and Oceania 2013 Munich Re Foundation, 2014
[8] Alliance for Inclusive Insurance: Discussion Paper Manoj Yadav, Chami Ousima and Uplift Development Services and Solutions, GIZ, 2015
[9] As per The landscape of Microinsurance in Asia and Oceania 2013 Munich Re Foundation, 2014, 48.11 million people were covered under some kind of life microinsurance product. A substantial part of this coverage is supposedly led by MFIs.
[10] According to The Landscape of Microinsurance in Asia and Oceania 2013 Munich Re Foundation, 2014, social microinsurance coverage in Asia and Oceania was 1.7 billion in 2012 – more than 10 times the voluntary coverage of 170.4 million. Social microinsurance coverage in India was reported to be over 310 million in this study.

Figure 4: Microinsurance models in India

Compulsory model (insurance bundled with credit products)	• Emerged out of "piggybacking" insurance with a fast-moving microcredit product • Credit life and index-based weather insurance products • Limitation: Outreach limited to microcredit customers
Subsidized model/ social insurance	• Premiums subsidized by the government, quickly acquired and in huge volumes • Term life, agriculture and health insurance covers offered to the ultra-poor households • Limitation: Lack of information and facilitation at the ground level and absence of effective monitoring mechanisms
Voluntary model (includes mutual insurance)	• Promotes microinsurance through hard selling, such as the mainstream insurance sector • Comprises a partner-agent arrangement with mainstream insurers as well as mutuals • Limitation: problems of scalability, financial viability and misselling, besides the inability to offer inorganic growth

Last comes the **"voluntary" model**, which promotes microinsurance through hard-selling, much like mainstream insurance that currently commands only modicum proportions in the sector. This model comprises of players working under the partner-agent arrangement with mainstream insurers as well as mutuals that carry the risk without recourse to a formal insurer. The sacrifice in insurance is real and immediate while the benefits are distant and contingent. While this makes voluntary microinsurance arduous, it also means that the positive impact of insurance on the society will be apparent only over a period of time.

This is possible only if people continue to remain insured for longer periods. The voluntary model by its very nature contains an in-built imperative to promote sustained insurance purchase, thus offering a better chance of a positive impact on vulnerability.

Due to these features, voluntary microinsurance is likely to remain an area of interest in the years to come, notwithstanding its inherent problems of scalability, financial viability and mis-selling, besides the inability to offer inorganic growth. Expanding outreach among the low-income populations beyond the captive catchments of compulsory and subsidized models will compel a persevered endeavor on the voluntary side.

Evidence of shortcomings in commercial microinsurance in India

Despite the growth of microinsurance in recent years, less than 10% of the Indian population and only 14.7% of the potential microinsurance market in the country are covered. In terms of coverage ratio (ie the number of people covered as a proportion of the target population), India was behind the Philippines (20.6%) and Thailand (13.9%) and much below South Africa which had a coverage ratio of more than 50% in 2011[11].

The consequences of this low insurance coverage can be extreme. For example, with take-up of existing Government and commercial crop insurance schemes by farmers as low as 23%, there have been more than 300,000 suicides farmers in India since 1995[12]. Articles from recent news publications have provided significant evidence to suggest that commercial microinsurance is failing to provide meaningful protection in areas such as life, health and crop insurance in India.

The failure of commercial microinsurance providers to meet the needs of the poor may be attributed to a lack of motivation by both insurers and distributors, and most commercial insurers still view microinsurance as a regulatory obligation[13]. Although every life and general insurance company needs to fulfil their mandatory rural and social sector obligation, a recent study found that only 14 companies (of a total of 47 companies) have registered microinsurance products with the IRDAI[14]. Furthermore, insurers do not make any money from it. For example, Indian insurance companies are consistently losing money on crop insurance, which accounts for only 6% of their overall portfolio, despite being the fourth largest segment in terms of premium collected[15].

As a result, insurers and supply chains have failed to provide innovative, sustainable and scalable microinsurance systems,[16] which can be connected to a lack of efficiency. For example, the insurance regulator has asked insurers to offer a better deal to customers and better returns on the premiums after it was found that insurers were guilty of inefficient control of management expenses[17]. Additionally, previous insurance schemes have been criticized for inefficient product design.

Commercial microinsurance is also failing to address some of the recognized key challenges of providing microinsurance to the poor, such as lack of awareness, low levels of financial literacy and proximity to the policyholder. For example, a 2012 sample survey shows that for crop insurance, a lack of awareness was a key culprits of low insurance uptake[18], and poorer households appear unaware of such coverage both in rural and urban areas[19]. In regards to financial literacy, 64% of respondents in a recent survey failed to identify whether they had bought a life or health insurance policy, without the help of the survey interviewer[20].

In such a situation MCCOs have a huge potential role to play in providing and improving risk management of the low-income population. The next section aims to present the current status of mutuals, the regulations that impact them, the mutual models that have emerged, and their characteristics.

[11] The Landscape of Microinsurance in Asia and Oceania – Briefing Note, GIZ and Munich Re, 2013
[12] Thousands of farmer suicides prompt India to set up $1.3bn crop insurance scheme. The Guardian, 14 January 2016.
Source: https://www.theguardian.com/world/2016/jan/14/india-thousands-of-farmer-suicides-prompt-1bn-crop-insurance-scheme
[13] MicroSave India Focus Note 88, Challenges of Microinsurance in India, MicroSave 2013
[14] Securing the Silent: Microinsurance in India – The Story So far, MicroSave, 2012
[15] Why crop insurance has come a cropper in India. Live Mint, 9 June 2016
Source: http://www.livemint.com/Politics/bIcTLmLxDTxiOTKTolCKLL/Why-crop-insurance-in-India-has-come-a-cropper.html
[16] MicroSave India Focus Note 88: Challenges of Microinsurance in India, MicroSave 2013
[17] India: Regulator asks insurers to control management expenses, Asia Insurance Review, 3 February 2016
Source: http://www.asiainsurancereview.com/News/View-NewsLetter-Article/id/34869/Type/eDaily?utm_source/Edaily-News-Letter/utm_medium/Group-Email/utm_campaign/Edaily-NewsLetter
[18] Why crop insurance has come a cropper in India, Live Mint, 9 June 2016
Source: http://www.livemint.com/Politics/bIcTLmLxDTxiOTKTolCKLL/Why-crop-insurance-in-India-has-come-a-cropper.html
[19] Health cover: Too little, too scarce, The Hindu, 12 April 2016
Source: http://www.thehindu.com/sci-tech/health/policy-and-issues/health-insurance-in-india-too-little-too-scarce-reveal-national-sample-survey-data/article8462747.ece
[20] 2 in 3 are risk-averse and opt for traditional insurance Asia Insurance Review 11 March 2016
Source: http://www.asiainsurancereview.com/News/View-NewsLetter-Article/id/35279/Type/eDaily?utm_source/Edaily-News-Letter/utm_medium/Group-Email/utm_campaign/Edaily-NewsLetter

SECTION III: MUTUAL AND COOPERATIVE INSURANCE IN INDIA

The MCCO space within the overall insurance and microinsurance environment of India is still very small. Since MCCOs currently operate out of regulatory purview, there is hardly any information available on the number of mutuals operating in the country, the volumes they generate, the type of products they deal in, etc. Moreover, in some cases the models are so complex that it becomes difficult to make out whether a particular program is or is not a mutual arrangement. Most of the organizations offering mutual insurance services are not comfortable in sharing the finer points of their model and their statistics so freely. All this has meant that there is hardly any credible information available on mutuals in India, except for the well-known programs such as DHAN Foundation, Uplift Mutuals and VimoSEWA.

Characteristics of MCCOs

As mentioned in the section on research methodology, a survey was conducted amongst mutuals and key stakeholders to gather data on MCCOs. It was found that MCCOs have certain common characteristics:

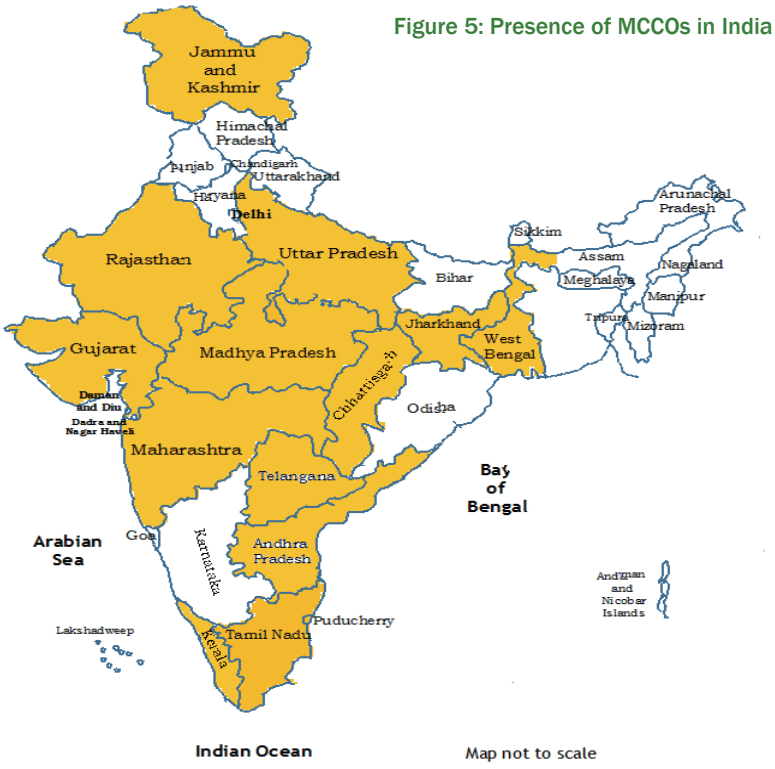
Low-income clients with women-led membership: All the MCCOs studied, except for the Calcutta Hospital and Nursing Home Benefits Association Limited (CHNHBA), serve low-income households and in over 90% of cases the policyholders are women. This is mainly because most of the MCCOs have emerged from SHGs or microcredit operations that have been traditionally developed with women.

Presence in most parts of the country: The mutual model can be found all over India except for the north eastern states. The mutual model and its variations have been found to exist in Jammu and Kashmir, Madhya Pradesh, Uttar Pradesh, Chhattisgarh, Jharkhand, West Bengal, Maharashtra, Rajasthan, Gujarat, Tamil Nadu and Kerala. Most of the MCCOs have their presence in rural India while a handful of them also have a presence in urban slums.

Limited outreach: The majority of the MCCOs have small membership numbers with some having as little as 1,400 policies covered. Only three organizations have lives covered over 200,000 (Uplift Mutuals, DHAN Foundation and EASF) under a typical mutual model. **The total number of lives covered under mutual microinsurance is 1,197,077**. However, it should be noted that a handful of MCCOs also run the partner-agent model where their outreach is in excess of 1.2 million lives. MCCOs that started as mutuals, graduated their members into the formal partner-agent model once the mutual model proved that they were insurable.

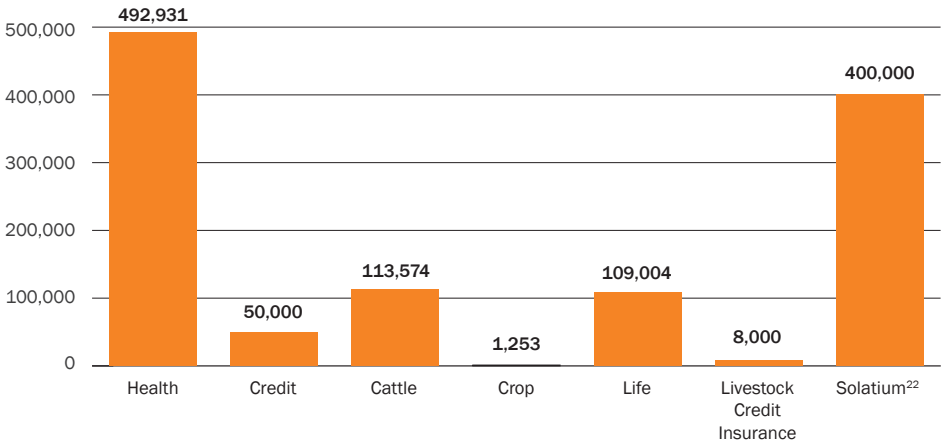
Product portfolio consists of health, credit life and cattle: The product portfolio is led by health, signaling the need for "bottoms up" approach in health microinsurance. These are followed by livestock and life microinsurance. The high number of lives covered in health can be due to the fact that around 90% of the healthcare expenditure in India is out-of-pocket[21].

Figure 5: Presence of MCCOs in India



[21] Understanding the 'Missing Middle' in Insurance: A study of Urban Poor households in Mumbai and Pune, GIZ, 2015

Figure 6: Product profile and number of lives covered by MCCOs



Non-profit and community-based governance: MCCOs are largely organized as not-for-profits, while some of the very recent ones have not even been legally formalized. Only a couple, such as VimoSEWA, are registered as a Multi State Cooperative.

> At Uplift Mutuals, the Claims Committee, an elected body of the members, is the designated body to make decisions on claim payments. Members of the Claims Committee are trained by Uplift on taking decisions based on product guidelines.
>
> On a decided day of the month, the Claims Committee sits to make decisions on recent claims payments (that have been medically validated by a doctor), based upon a set of parameters clearly spelt out. Uplift has prepared a Claim Decision Tool (CDT) which has most of the risk management guidelines inbuilt into it which forms the basis of the decision making.

Catering to mostly low-income groups, it seems most of the MCCOs prefer to be under a non-profit registration (eg DHAN Foundation, The Goat Trust and Uplift Mutuals), as it enables them to raise donor support in the absence of any capital support from investors.

While those registered under cooperatives have a very clear member governance in place, the other MCCOs run their governance by using representatives from their members either on the board or through a special committee to decide on product design, claims decisions and risk management, profits and losses of the mutual, and the day-to-day running of the program. At many places members are involved in the day-to-day running of the operations and are also shareholders. Some have very detailed roles and responsibilities laid out for community representatives and have intensive training modules in place to build their capacities to manage their mutual program.

Small ticket size premiums and priority to risk reduction services: The average premium size of these MCCOs across health and life products is about USD 2-4 per annum, and for livestock it is USD 3-10 per annum. While the premium size is small, it does not reflect the host of risk reduction services that provide tangibility to these products and are often aimed at reducing risk. These risk reduction services ensure that the focus of these programs is not just providing insurance like services but to aid low-income families in hedging or reducing the risk bettering the quality of risk being covered. If these are factored into the premium cost, then the premiums would be much higher than they currently are. Similarly, the kind of indirect benefits of risk reduction that reduce the burden on claims would be higher, if calculated.

Figure 7: Legal form of mutual schemes currently in existence

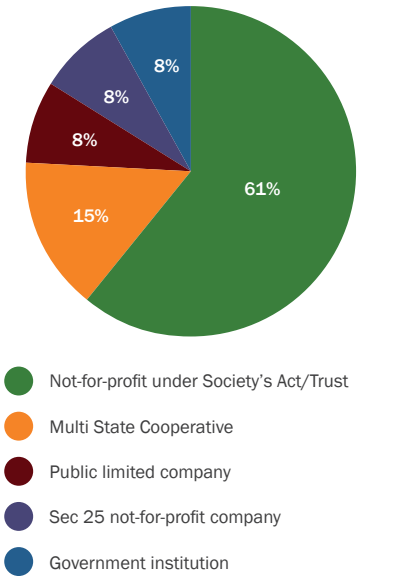


Figure 8: Age of the schemes

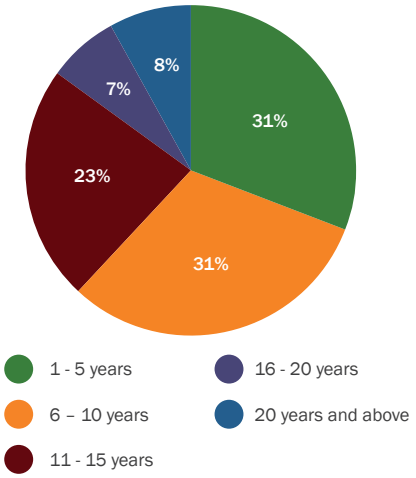
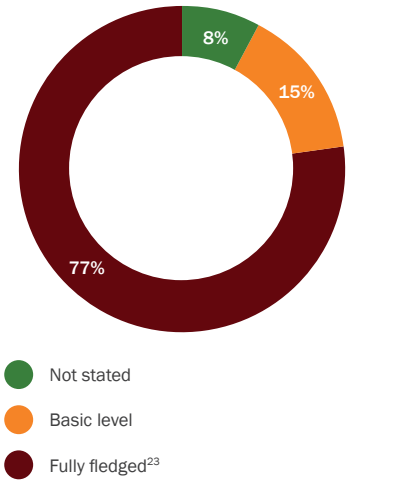


Figure 9: Presence of risk-mitigation and value-added services



[22] "Solatium" is also sometimes referred to as a "solidarity fund", it is made up of pre-decided contributions directly or indirectly paid by the beneficiaries. The fund is used to defray the losses arising out defined risks.

[23] "Fully fledged" means risk mitigation and value added services are offered on a regular and planned basis and are part of the overall organization strategy. "Basic level" refers to one-off and sporadic risk mitigation service.

Simplified claims processes that buck moral hazard: One of the major reasons that the majority of these MCCOs started microinsurance with the mutual model is the tedious and tiring claims process. At these MCCOs, claims processing is relatively simple as the decision makers are in close proximity to the claimant. The claims processing time is on average 30 days[24] coinciding with the monthly meetings of these MCCOs where the claims are discussed. The claims decision process is a transparent one where rules that have been commonly agreed are applied and the affinity of the members helps in reducing the chances of fraud and moral hazard.

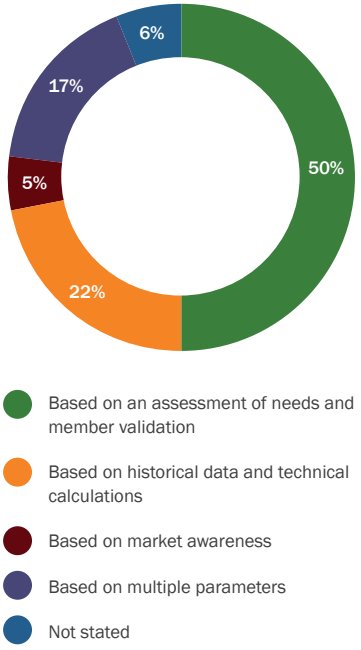
Product designed in consultation with communities: Most of the MCCOs design their products in consultation with their target communities. Some of them hold surveys, FGDs and technical analysis of risks to be covered, while others use the "rule of thumb" (mostly for cattle) to arrive at product design. Premium, exclusions, claims processes; almost all the steps have the members playing a major role in finalizing the product. Some MCCOs also use actuarial advice to design their product.

At The Goat Trust, risk cover is ascertained through Participatory Rapid Appraisals (PRA). While normal cattle insurance covers only mortality, PRAs conducted by The Goat Trust revealed that infertility and paralysis were also major risks that needed to be covered.

The premium is arrived at by taking 10% of half of the value of the goats. For example, INR 150 (USD 2.3) would be the risk premium if the cost of the goat is INR 3,000 (USD 46) (ie 10% of half the cost of the goat), with INR 165 (USD 2.5) being the average premium, INR 15 (USD 0.2) is added for risk reduction services like deworming, vaccination and a health checkup.

Similarly, at DHAN Foundation, when they decided to first pilot Index Based Weather Insurance on a mutual basis, the farmers participated in the product design.

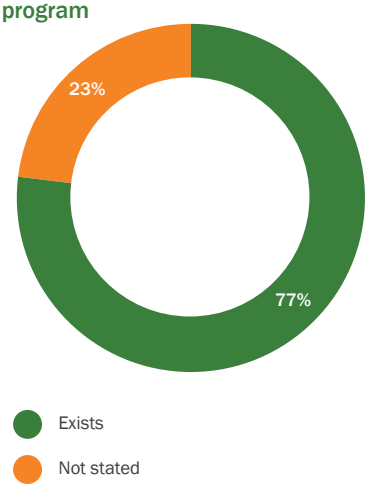
Figure 10: Product design process



Focus on insurance education: One of the most defining features of MCCOs has been their focus on educating their members on risk, risk sharing and risk mitigation. The majority of MCCOs identify lack of general insurance awareness as their main hurdle to growth. Hence, almost all of them have dedicated education modules in place that are aimed at making the members insurance literate. Many of them deploy games, simulations and role plays to not only make members understand insurance but also the roles and responsibilities that a solidarity-based model needs. MCCOs spend roughly about 20% of their operating costs on insurance education and have developed a wide variety of audio-visual tools to aid this education process. These education programs are conducted on a weekly or monthly basis and can last from 15 minutes to an hour. They also have separate programs for existing and new clients. The topics covered under these education components include:

- Risk identification and prioritization.
- Concept of insurance.
- Concept of mutual insurance.
- Product education, including exclusions.
- Claims and renewal processes including claim rejection.
- Roles and responsibilities of members.
- Training to use the value added services.

Figure 11: Dedicated consumer awareness program



[24] Uplift Mutuals recently conducted a trial of settling hospitalization claims within 48 hrs and is readying its back office likewise

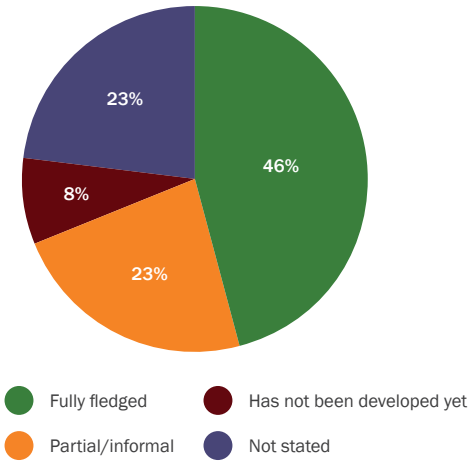
Figure 12: Uplift Mutuals: Insurance awareness is in-built in all steps of insurance delivery

- **Promotion:** This is the first event when the fieldworker gives the introduction of the HMF product to the member
- **Orientation:** Detailed information about the product contribution, benefits and services is given
- **Nidhicard distribution:** Welcoming members into the fund, providing complete information on the policy, how to use referrals and make claims, and clearing any doubts the member may have, if any
- **Claims meeting:** Whilst discussing claims, the members are once again infomed how to use Uplift's services, network hospital and referral services
- **Health check-up camps and health talks:** Brief information about HMF is provided, with posters and charts
- **Agorya Nidhi helpline:** For referrals and discussing policy claims in detail
- **Fund information, governance meetings and training:** Monthly committee meetings and training of elected representatives, fund information and service charts

Existence of a grievance redressal mechanism: One important feature found in MCCOs is the existence of a grievance redressal mechanism that allows members to voice their complaints formally. Some of the MCCOs have dedicated customer care departments while others have designated processes and committees to look into member grievance. At some MCCOs, members can call to register their complaints while at others it is mostly during monthly meetings with field staff and community leaders. MCCOs place importance on getting a grievance addressed early, as this reinforces the mutuality aspect of the program and helps in client retention.

VimoSEWA has a dedicated customer care department which serves mutual insurance customers as well as insurance customers of the partner-agent model. This customer care department is responsible for all grievances received by phone or through walk-in customers. VimoSEWA also conducts weekly or fortnightly meeting with all VimoSathis and Aagewans (sales persons) who are directly in touch with end users to discuss grievances or to address complaints.

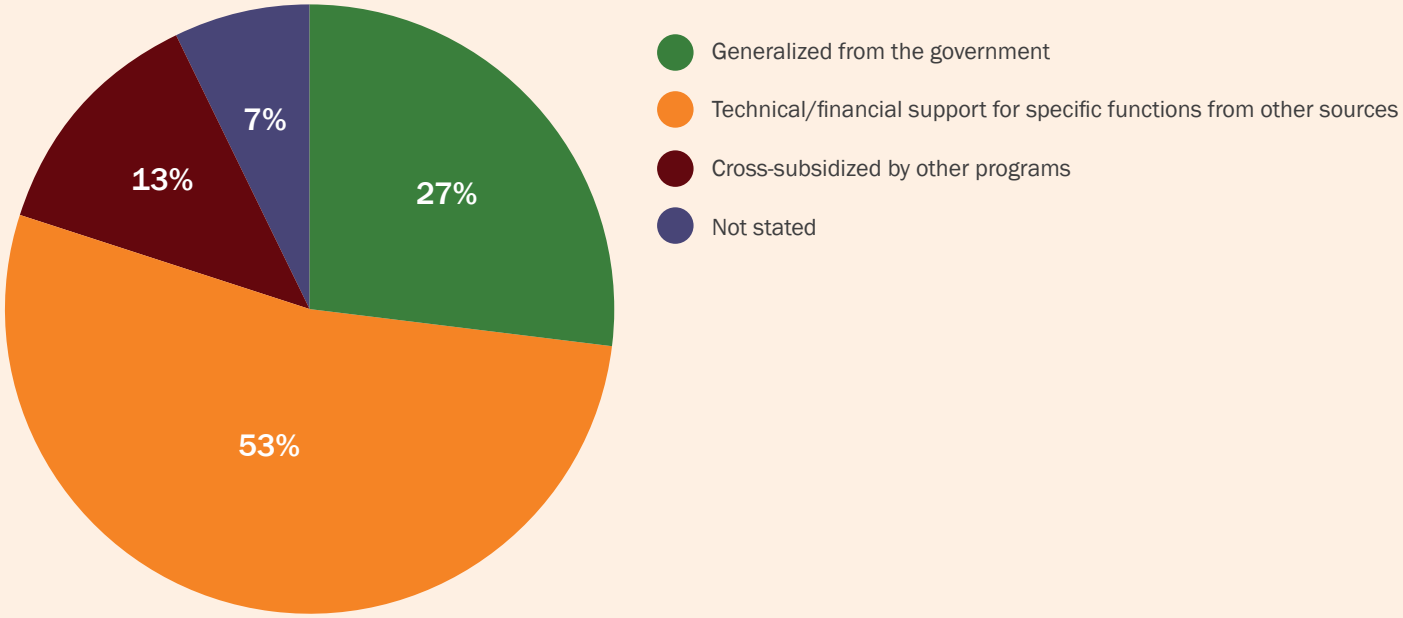
Figure 13: Presence of a grievance redressal mechanism



Financial sustainability: Very little data could be obtained about financial sustainability. However, in cases where data was available it shows that within the MCCOs the pure risk retention component has achieved breakeven (claims are being managed within premiums), while risk reduction services still need funding or are being cross-subsidized by other programs. Almost all of the MCCOs have received some form of support from donors or the Government in either setting up the scheme or running the scheme. 27% of the schemes have direct government support, or support from a government scheme, while the majority have received either technical support or grants to set up and run the scheme.

MCCOs need funding for expansion and setup as they do not have access to formal channels of capital. One of the main reasons for mutuals being limited to a particular geography is also the fact that they do not have sufficient operating margins to expand into newer geographies.

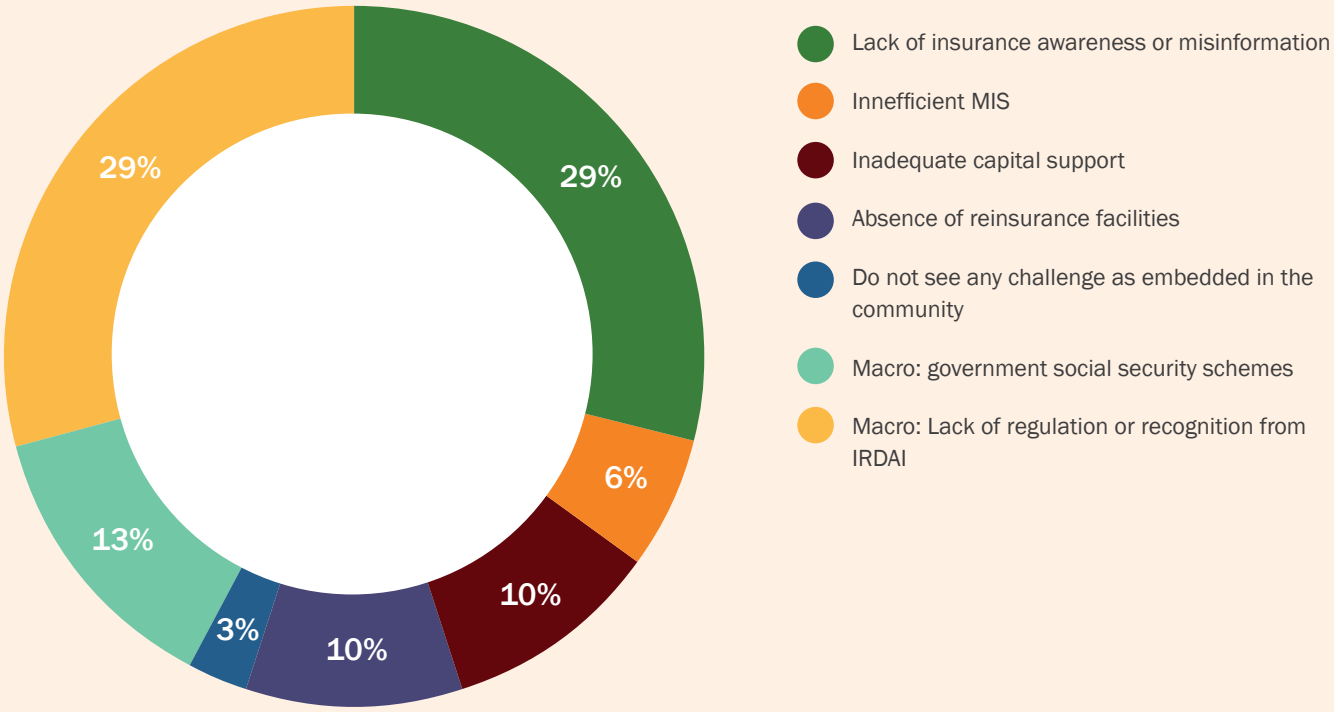
Figure 14: Financial support



Operational and growth challenges

For the majority of MCCOs, lack of insurance awareness (29%) and legal recognition (29%) were the top two major concerns with regard to the growth and maturity of their schemes. In order to serve their members some of them have coopted with the partner-agent model but at an organizational level they have been trying to advocate the mutual model to various levels of Government and regulatory bodies. The lack of information on insurance, or rather the misinformation or earlier bad experiences with similar insurance products, was highlighted as a major concern in the growth of the schemes.

Figure 15: Operational and growth challenges

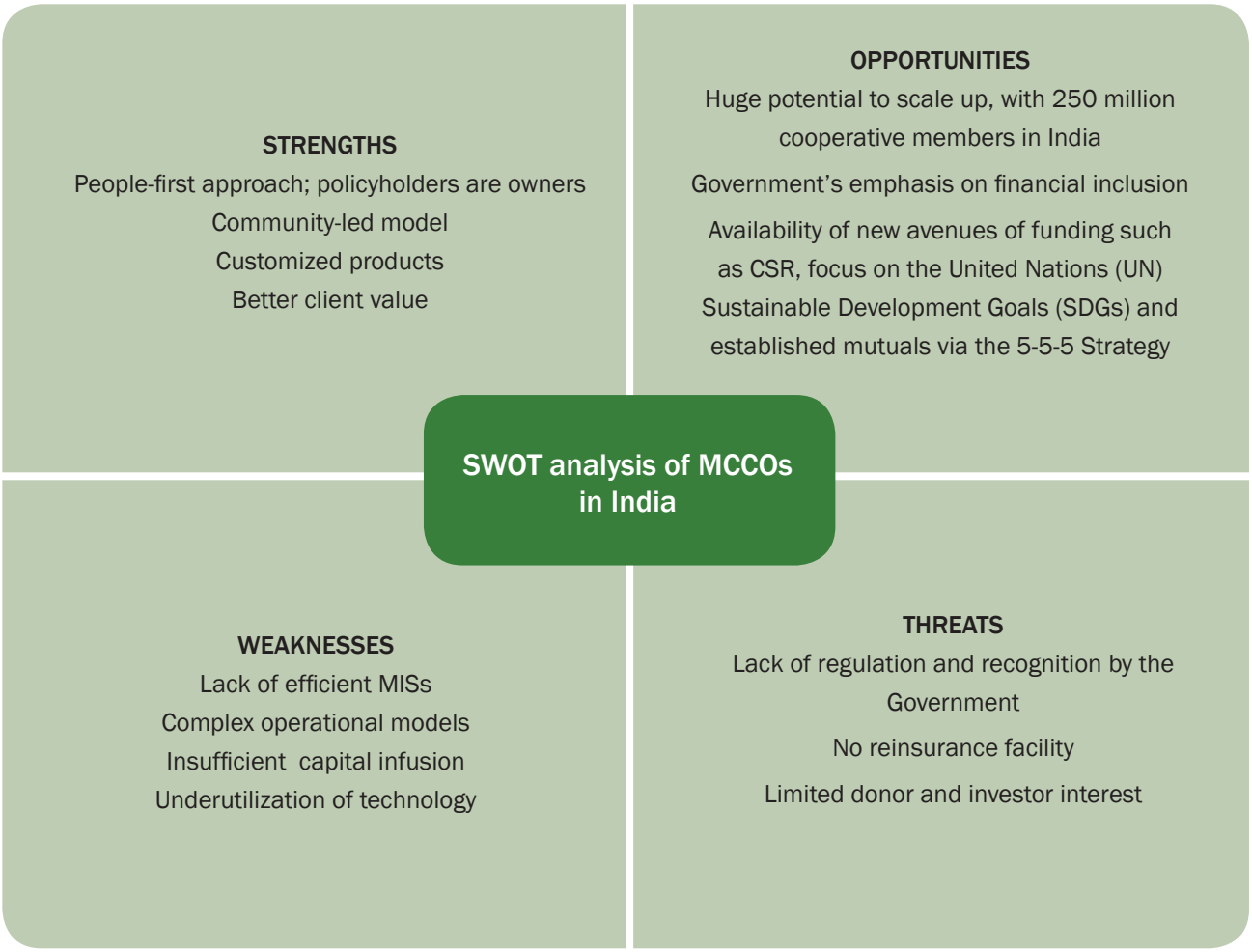


A handful of MCCOs have dedicated and advanced MISs for tracking their mutual portfolio. For others, collected data is stored as raw data on MS Excel. MCCOs are aware of the efficiency technology brings but find the cost of building a MIS system prohibitive. Some of the MCCOs feel that development of mobile technology can be a game changer in reducing servicing cost and becoming the "last mile" delivery platform.

In the absence of regulation, MCCOs do not have access to reinsurance facilities making them extremely conservative about growth and expansion. Most of them have also adopted the partner-agent model in order to address growth issues. Some use the existence of Government sponsored schemes to cover high cost risks that they may not be able to cover, especially in the case of hospitalization risks. In some circumstances, donors have provided grant arrangements to cover losses.

The non-availability of reinsurance for mutuals in India, given the regulatory vacuum, can thwart their seamless growth and may restrict them to certain risks and geographies. This can also result in an increased cost of capital for mutuals and the resultant burden on the insured population. As mutuals grow in the size and diversity of risks they underwrite, this issue of the availability of reinsurance also needs to be addressed. **Market-based solutions like buying group covers with higher deductibles from formal insurers could be a solution but this again can put a question mark on the degree of mutuality with which mutuals will be able to work.** Even if reinsurance is made available through an arrangement, not all mutuals will have the necessary volumes to justify a treaty arrangement. This may lead to the need for some kind of aggregation arrangement for mutuals before those risks can be offloaded to reinsurer.

Figure 16: SWOT analysis of MCCOs in India



Types of MCCO models

A regulatory vacuum and market failures have prompted players to devise their own unique 'models' that carry one or more basic features of a mutual. The absence of market-led or regulatory benchmarks for mutuals in India is both an opportunity as well as a challenge. As an opportunity, this offers a wide range of structures, products, processes and programs with varying levels of mutuality, thereby creating a pleasant diversity within the mutual world. The study found three distinct mutual insurance models in the country, namely the mutuals promoted by MFIs to manage their credit risks, the community led "pure" mutual model, and the delivery of insurance-like services through the cooperative structure.

Mutuals promoted by MFIs: Many MFIs engaged in microcredit activity carry the risk of default in the event of the death of the borrower (for example, ESAF in Kerala and SEWA Bank in Gujarat). This is done either because of non-availability of formal insurance coverage or on account of the presumption that retaining the credit life risk is more profitable than transferring the same to formal insurers. In some cases, a separate fund is created out of the contributions charged from the borrowers. These contributions are either charged separately at the time of loan disbursement, or are factored into the installments to be paid by the borrowers. In other cases, no separate fund is maintained but the MFI just retains the risk of default in case of death of the borrower. Thus while the former arrangement of charging some premium (directly or indirectly) and putting it into a separate solatium fund can be considered to be some kind of mutual arrangement, the latter approach is just a risk retention decision of the MFI and cannot be considered as an insurance mechanism. Again, in both cases, it is not always clear whether the borrowers that contribute to the fund are also made partners in the profit of the solatium fund. It is also not clear whether the pricing for such a solidarity arrangement is done professionally. ***The mutual model followed by MFIs to handle their credit risk arising out of the death of a borrower is thus a loose mutual model and can vary substantially among various MFIs.***

Community led mutual model: The second mutual model is more apparent and clear, and is pursued by organizations mainly in the area of health and livestock insurance. In most cases under this model, the pricing, product design and the processes are formulated with full involvement of members, and members are also involved in adjudication of claims. Community ownership, and the involvement of the community in the governance of the program, ensures better client value and risk reduction and thereby helps in furthering the true purpose of mutuality. Among the organizations involved with this model, some are exclusively mutuals while some others engage in the mutual model as a part of their overall livelihood or microfinance program. Uplift Mutuals and The Goat Trust are prominent examples of this model.

Delivery of insurance-like services in India through the cooperative structure: This is the only model where the legal entity of the organization confirms and ensures its mutual character. There are various state as well as national level cooperative legislations under which a cooperative can be registered in India. The cooperative insurance entity is thus a cooperative society registered under any of these legislations. Here again, in most cases cooperatives undertake insurance as a subsidiary activity along with some primary activity in the area of livelihoods or microfinance. There are also few cooperatives that undertake insurance as their sole activity, such as the National Insurance VimoSEWA Cooperative Limited (VimoSEWA) which operates with the sole objective of providing insurance services.

This diversity of models can be very well leveraged to attain a decent scale for the sector as well as to find out the most effective models. On the other hand, the same diversity also carries the risk of rendering the sector fragmented and directionless, and for providing an open ground for some unscrupulous elements that can work against the fundamental spirit of cooperation and mutuality. **The challenge therefore in such a loose and fragile environment is to draw the best possible samples and test them on various parameters of financial and social performance in order to discover the right model(s) that best fits this environment.**

Regulations and MCCOs

History

Mutuals existed before independence. A mention of them can be found in the **Erstwhile Insurance Act of 1938** where mutuals and cooperatives are defined as follows:

(a) "Mutual Insurance Company" means an insurer, being a company, incorporated under the Indian Companies Act, which has no share capital and of which by its constitution only and all policyholders are members; and

(b) "Co operative Life Insurance Society" means an insurer being a society registered under the Co operative Societies Act, 1912 or under an Act of a State Legislature governing the registration of co¬operative societies which carry out the business of life insurance and which have no share capital on which dividend or bonus is payable and of which by its constitution only original members on whose application the society is registered and all policyholders are members.

Even when the Insurance Act of 1938 was amended via the **Insurance Amendment Act 2002**, it mentioned four types of insurance providers viz, (i) insurers registered under the Companies Act 1956, (ii) provident societies, (iii) mutuals providing insurance policies, and (iv) cooperative societies. The Act also defined these entities separately; Section 95(1) (a) and (b) defined mutual insurance companies and Cooperative Life Insurance Societies respectively.

Another interesting fact about mutual insurance comes to light when one reads **The General Insurance Business (Nationalization) Act, 1972 (GIBNA) as amended in 2002**. This amendment specified that all shares in the capital of every Indian insurance company shall, by virtue of this Act, stand transferred to and vested in the Central Government and the formation of General Insurance Corporation of India. Some specific exemptions were provided under the GIBNA, which under Section 36 stated that *"(1) Nothing contained in this Act shall apply in relation to . . . the insurance business carried on by the Calcutta Hospital and Nursing Home Benefits Association Limited."* The CHNHBA was perhaps the only mutual allowed to exist in independent India until the 2015 Act.

The GIBNA also specified that *"(2) If the Central Government is satisfied that an insurer, whether established before or after the appointed day, carries on only such general insurance business as is not carried on ordinarily by insurers, it may, by notification, direct that nothing contained in this Act shall apply to such insurer (emphasis added)."*

Current status

In the very recent amendments for the insurance sector, the mention of mutual insurance does not exist. The Insurance Laws Amendment Act of 2015[25] has defined "insurer" under Section 2 (9). While it includes under *"an insurance co-operative society", under sub-section (c) no* definition is provided for mutual insurance companies. Under Section 8A, an insurance cooperative society now means any insurer being a cooperative society. However, there is no difference in the treatment of such cooperative societies in terms of minimum paid up capital, which continues to be INR 1 billion (USD 15.4 million)[26].

[25/26] The Insurance Laws Amendment Act of 2015 has modified the definition of cooperatives as underlined below:
(8A) "insurance co-operative society" means any insurer being a cooperative society,
(a) which is registered on or after the commencement of the Insurance (Amendment) Act, 2002, as a cooperative society under the Cooperative Societies Act, 1912 (two of 1912) or under any other law for the time being in force in any State relating to Co-operative Societies or under the Multi-State Co-operative Societies Act, 1984 (51 or 1984);
"(b) having a minimum paid-up capital, of rupees one hundred crores; in case of life insurance business, general insurance business and health insurance business;" (added vide new Act)
(c) in which no body corporate, whether incorporated or not, formed or registered outside India, either by itself or through its subsidiaries or nominees, at any time, holds more than twenty-six per cent of the capital of such Cooperative Society;
(d) whose sole purpose is to carry on life insurance business or general insurance business or health insurance business in India.;"
(added vide new Act)

The Insurance Laws Amendment Act of 2015 seems to have excluded mutuals from its scope as it clearly prohibits transactions of insurance business by certain persons. The revised Act allows only (a) a public company, or (b) **a society registered under the "The Companies Act, 2013", or under any other law for the time being in force in any State relating to co-operative societies**, or (c) a body corporate, incorporated under the law of any country outside India, not being of the nature of a private company to transact insurance business (details are in **Annexure C**).

Various studies have been examined to understand the legal and regulatory position of mutuals and cooperatives and the same can be found in Annexure C.1.

Gaps in the legal position after revision of the Act in 2015

Whether removal of all provisions relating to mutuals indicates a concrete decision by the Government that this sector does not need to be regulated?

The changes may be construed as benign for mutuals, if the Government's intentions were for the following reasons;

i. it does not intend to regulate the segment as it is too small to be regulated in terms of risk carried, volumes generated, number of operators etc (ie not to "over-regulate");
ii. believes that mutuals are better left benignly unregulated so that their growth is not hampered by regulations (allow development by not regulating); and
iii. thinks that the regulator need not spend its resources regulating this currently tiny segment, thus compromising the regulation of other insurers (ie optimizing regulatory capacity).

The changes may have serious consequences for mutuals and cooperatives, if the Government's intentions are based on the following reasons;

iv. no intention to differentiate between types of insurance providers or by the insurance product lines (eg health insurers needed only INR 0.5 billion, USD 7.69 million, of capital in the past) for purposes of capital requirement and wants only deep-pocketed players in the industry;
v. does not wish to accept the existence of mutuals or promote the mutual model of providing insurance services as a means of reaching out; and
vi. intends to give a strong message to the existing mutuals to fall in line or close down, which might be followed by legal compulsion.

The reasons for having taken such a stand could have been because the Government;

- believes that only large cooperatives who can bring in INR 1 billion (USD 15.4 million) of capital (or more) would have the capacity to provide insurance solutions and is not confident that small mutuals can scale up to commercial levels;
- has more trust in the cooperative insurance model than in the mutual model, given the fact that no mention of mutual insurance is there in the revised Act of 2015;
- wants only deep-pocketed players (minimum capital requirement is INR 1 billion or USD 15.4 million) in the industry; or
- may have plans to categorize mutuals as an alternative model for "below poverty line" (BPL) customers, later on.

Opportunities for MCCOs to fill the legal void

In the given context, MCCOs can adopt a range of strategies from converting into a cooperative insurer, approaching the courts, or to simply maintain the status quo. Some of which are outlined below:

- **Conversion into cooperatives:** capital requirements, legal issues and procedural issues are challenges to this.

- **Advocacy with the Government/regulator:** citing Section 94.A of the Act, arguing that the legislature has clearly envisaged the need to make special exceptions for cooperatives and has empowered the insurance regulator in this regard. It is likely that there would be a road block (in the absence of a clear Act provision and an Act amendment) as the IRDAI has to use the exemption provisions imaginatively and boldly as there is no clear way ahead in the Act.

- **Approach the court for judicial redress** pointing out that the revised Act has left a regulatory void which has caused the following effects:

i. CHNHB, a pre-existing mutual, has been "grandfathered" into the GIBNA, leaving its direct beneficiaries in a vacuum.
ii. Affecting mutuals of subsequent origin like Uplift Mutuals, VimoSEWA, SERP, DHAN Foundation etc, and the vast majority of the population who are direct/indirect beneficiaries of these endeavours.
iii. Depriving people who are beyond the mainstream of commercial insurance operations of the benefits of insurance, which commercial insurers will not be able to provide for many years to come.
iv. Defeating the Government's stated policy of financial/insurance inclusion and reaching out to the underprivileged.
v. Creating evidence of the negative fall-outs of the regulatory void generated by the new provisions

- **Mustering the support** of all similarly placed entities inside and outside the country for advocacy and for seeking legal redress

"94A. Insurance co-operative society to be an insurer:

(1) Every insurance co-operative society shall be deemed to be an insurer for the purposes of this Act.

(2) Save as otherwise provided in this Act, all the provisions applicable to as insurer being an Indian insurance company shall, so far as may be, apply to an insurance co-operative society; provided that the Authority may, by notifications, direct that any of the provisions of this Act,
a. Shall not apply to any insurance co-operative society; or
b. Shall apply to any insurance co-operative society only with such exceptions, modifications and adaptations as may be specified in the notification.

(3) A copy of every notification proposed to be issued under sub-section (2) shall be laid in draft before each House of Parliament, while it is in session, for a total period of thirty days which may be comprised in one session or in two or more successive sessions, and if, before the expiry of the session immediately following the session or the successive sessions aforesaid, both Houses agree in disapproving the issue of the notification or both Houses agree in making any modification in the notification, the notification shall not be issued, or, as the case may be, shall be issued only in such modified form as may be agreed upon by both the Houses."

By its very nature, a cooperative is born as a small entity and only then can it grow. The amendment to the Insurance Act in 2002 therefore practically rules out the entry of cooperatives in the insurance sector. Persons associated with ICMIF could take up this matter during their personal depositions to the Parliamentary Select Committee (PSC) looking into amendments to the Insurance Act. The PSC acknowledged the need to promote cooperatives in the insurance sector in the interests of the low-income population and to reduce the initial capital requirements for cooperatives suitably. It is now up to the PSC to convince the Government to act upon the same.

Of late, there have been indications that the long-pursued philosophy of having a small number of large players at the manufacturing level could be changing for good. Following the recommendations of a high-powered committee, the banking regulator has decided to create a separate tier of small finance banks and small payment banks in India. Licenses have recently been issued under these categories. This signifies a welcome shift in the policy governing financial services regulation. If this trend continues, it may not be long before a similar change is also initiated for insurance regulation.

SECTION IV: MARKET POTENTIAL FOR MCCOS IN INDIA - ISSUES AND CHALLENGES

Insurance penetration in India still remains pretty low. In fact, the insurance penetration rate has actually declined in the past few years signifying that the growth of the insurance sector has not been able to keep pace with the overall economic growth. [27]Hence despite the increasing outreach through compulsory and subsidized models, insurance still seems to be elusive to a vast majority of the population. Even the insured population suffers from a high level of cognitive dissonance due to poor servicing, lack of transparency and absence of credibility on the part of mainstream insurers. The mutual option will obviously be a welcome development for such clients.

Commercial insurers often do not have the inclination to undertake proper consumer/ client education, and as a result of this insurance is most often pushed without creating the right risk perception among the consumers. Moreover, consumer education often calls for a huge investment that pays back only in the long-term and hence is never taken up in the right earnest by any stakeholders. The very structure of a mutual, coupled with its mutual spirit of help, ensures the incorporation of consumer education as an integral part of the operating model rather than as a separate project. This makes educating the member a "way of life" for most mutuals. It is clear that if mutuals can attain scale by maintaining the same approach towards consumer education, this will become a major unique selling point (USP) for mutuals.

India has over 595,000 registered cooperative societies at various levels. The total membership of all these cooperatives put together is almost 250 million.[28] This means that one in every five Indians is a member of a cooperative. Cooperatives in India range from tiny village level enterprises to million dollar brands. All this constitutes a potential market segment for MCCOs in India. The financial cooperatives, such as primary agricultural cooperative societies (PACS), district cooperative banks (DCCBs) and state cooperative banks (SCBs), are playing a significant role in the financial inclusion of the excluded rural and low-income households. The financial cooperatives also have a huge potential for mutual insurance as they share a distinct affinity towards mutuality and self-help. Moreover, these financial cooperatives are well-versed with financial activities and hence can take up insurance as one of their core activities quite easily.

The number of non-governmental organizations (NGO) in India is estimated to be more than 2 million with an estimated grant funding of USD 1.5 billion[29] to finance developmental activities.[30] With the changing developmental funding scenario, most NGOs are looking at some sustainable activities that can complement their revenue streams. Distributing insurance through mutuals could be one activity which NGOs can be motivated to take up along with their other core social activities.

The mainstream insurance sector has by and large failed in mobilizing all these sources. The primary reason for the same is reluctance on the part of these social sector organizations to work with insurance companies who have a for-profit mindset. The insurance industry hardly understands this market and thus has not succeeded in building their capacities to the required level. These organizations are likely to have a natural affinity towards mutuals and cooperatives and are more likely to align with them on a long-term basis, if mutuals are ready to invest in their capacity building.

Thus, while there may not be a ready market for mutuals in India, the right kind of positioning by mutuals and sourcing through these untapped channels definitely holds a good potential.

[27] Overall insurance penetration (for life and non-life insurance put together) was 5.2% in 2009 and has declined to 3.4% in 2015: IRDAI Annual Report, IRDAI, 2015-16.
[28] National Cooperative Union of India (www.ncui.coop).
[29] INR 97.5 billion
[30] Data for 2010-11. India witnessing NGO boom, there is one for every 600 people. Source: www.timesofindia.indiatomes.com.

Potential for Takaful in India

India is home to second largest Muslim population in the world after Indonesia[31]. Various Government reports have highlighted acute under-representation of Muslims in the overall financial sector for religious and other reasons. Community leaders and scholars abhor commercial insurance, as it trades in risk instead of sharing it. Premiums collected from policyholders are overwhelmingly invested in interest-bearing securities that are prohibited in Islam. In addition, the relationship between the insurer and insured (in proprietary/ commercial insurance) is interpreted as contractual ambiguity and conflict of interest. For all these reasons Muslims in general tend to avoid subscribing to insurance policies offered by commercial insurance companies.

Takaful is a form of insurance that seeks to address these concerns and provide security and insurance without violating the religious sensibilities of a community. There are more than 200 Takaful companies operating in various countries trying to tap into this niche market segment. **Takaful intrinsically is a mutual form of risk management in which the role of the insurance company is reduced to a service provider to manage entire operations on behalf of the policyholders, either for a fixed fee or for a share in underwriting surplus, or both.** In the case of a shortfall in underwriting accounts, a temporary liquidity facility is arranged by the insurance company known as a Takaful Operator (TO) which is recoverable from future contributions.

A great majority of Muslims live in urban and semi-urban areas and are engaged mostly in the unorganized sector characterized by unpredictable income and no social security[32]. They need products that are designed as per their specific needs and without compromising on their religious sensibilities. Insurance products that target this segment of the population on the basis of mutual cooperation and solidarity, and where income is not earned through interest-based investment, will be of immense help to this vulnerable section of society.

Government policy in recent years has been to explore innovative ways to improve financial inclusion and protection. Recently, Indian financial regulators have allowed many products and schemes that specially target Shari'ah compliant/conscious customers (provided they are not made exclusive to a particular community). Emergence of many MFIs on an explicitly Shari'ah compliant basis is also an indication of Government willingness in this direction.[33] It is noteworthy that the national reinsurer, General Insurance Corporation of India is providing Islamic Reinsurance (Re-Takaful) services to many Takaful companies in the Middle East and elsewhere.

It is very likely that a scheme based on the Takaful principle to serve the lower strata of people will find appreciation at all levels (community, scholars, the Government and regulators) provided it genuinely serves the targeted segment and is self-sustainable in the long run. **Some of the mutual models or risk retention schemes that exist in India already have concurrence with Takaful principles and serve as signposts for providing such solutions to the vast uninsured populations.**

[31]According to the Indian Census 2011, the Muslim population is 172.2 million (14.2% of India's total population). Currently it is estimated to be above 180 million. The average growth is 2.44% per annum.

[32] Sachar Committee Report, 2006

[33] Securities and Exchange Board of India (SEBI) has permitted exclusive Shari'ah Compliant Mutual Fund Schemes (Like Tata Ethical Fund and Taurus Ethical Fund). The only condition is it should not exclusively be offered to only one community. But then nobody would want to restrict their investors base. SEBI has also approved Shari'ah compliant Venture Capital Fund (VCF) (named: Secura India Real Estate Fund). In recent many exclusive Shari'ah compliant MFIs have emerged both at state levels as well as at the national level. Janseva, Al-Khair, Sanghmama are the societies that received registration and approval from the Ministry of Agriculture and Cooperation Delhi. There are many more which have copied this model and got registered at their respective state level.

Scale, sustainability and mutuality

As mentioned earlier, scale as well as client value are major determinants to the sustainability of an insurance venture. The global experience with microinsurance so far indicates that one often comes at the cost of another. While mass insurance approaches, such as compulsory, subsidized or automatic insurance schemes, have succeeded in attaining scale, their performance on client value and utilization is far from encouraging. These approaches thrive on the theory that insurance can never be sold actively in huge volumes and hence it is only through a "passive" solution that real numbers can be achieved. The presumption here is that once a decent scale is attained, demonstration of the effect of claims being settled will create a wholesome demand for insurance. However, there is no concrete evidence substantiating this hypothesis. On the contrary, experience shows that insurance continues only as long as the compulsion or the subsidy element of the program is available. People stop buying insurance the moment they have a choice or are made to pay for the same.

On the other hand, voluntary schemes for the low-income segment (including mutuals) have been focusing on the hard-selling element and investing heavily in consumer education. As a result of this, voluntary insurance and especially the mutual model of microinsurance has performed well on social performance indicators like renewal rates, utilization rates and overall client value. However, in this process, many of them have not been able to attain a decent scale and are thus struggling to attain financial viability.

The mutual philosophy of insurance emphasizes optimum community participation in areas like product design, enrolment and claims adjudication. With this process, mutuals are able to not only attain decent client value but are also able to control adverse selection and moral hazard. Moreover, community participation and ownership also ensures that the transaction and acquisition costs are kept at a bare minimum which ultimately contributes to financial viability of the program. Therefore, **mutuals are best poised to overcome the scale versus client value conundrum faced by mainstream insurance players.**

At the same time, this strength carries the risk of being turned into a weakness as the mutual grows. It becomes increasingly difficult to maintain the level of solidarity among the beneficiaries and ensure an optimum level of community participation as the mutual grows in size. It has been observed that while community ownership and solidarity produce marvellous results, constant hand-holding and facilitation is always required in order to maintain the efficacy of these processes. This becomes difficult to sustain as the mutual grows with the result that it has to then start relying on conventional processes of enrolment and claims adjudication, thereby losing the flavour of mutuality. **The threat of losing the mutual character as the program grows is a credible challenge that mutuals in India will have to overcome, but is not insurmountable as examples from large mutuals outside of India have shown.** Perhaps the use of technology and maturing of the insured population over a period of time could be the answers to this challenge but how exactly this can be done needs to be worked out as retaining mutuality, while growing, is a key consideration for the upscaling of mutuals in India.

Examples of established mutuals outside of India

P&V (Belgium)
The Co-operators (Canada)
MGEN (France)
FMG (New Zealand)
Folksam (Sweden)
Benenden Healthcare Society Limited (UK)
NFU mutual (UK)
Thrivent Financial (USA)

Return to the partner-agent model

It is a well-established fact that market failure has been an important driver behind the emergence of mutuals. This study has also corroborated this fact, with many mutuals acknowledging that non-availability of commercial insurance products was one of the major reasons for them to consider a mutual product. Despite all its positive aspects, developing and administering a mutual program is quite arduous and the tendency to slip out of it at the first opportunity cannot be ruled out. As the commercial insurance market in India develops, there is going to be strong competition from this side that the mutuals will have to withstand. This could be a tough call especially for those who have not been able to attain a decent scale in the mutual model. On the other hand, if the regulations remain unsympathetic towards mutuals, as they are right now, it would leave very little space for mutuals to play with. **Market forces as well as regulatory roadblocks could very well force some of the mutuals to go back to the conventional partner-agent model.** This is a challenge that needs to be addressed effectively.

SECTION V: THE WAY FORWARD

The study observed that the need for cooperatives and mutuals stemmed only from a market failure of commercial insurers over the years to provide the low-income population with the risk management solutions that are needed. The fact that 13 mutuals and two cooperatives have been able to touch the lives of more than over a million people in 13 states proves the potential of this model.

There could be various arguments for and against regulating or recognizing mutuals. However, all stakeholders should recognize that there is a clear need in India for mutuals and cooperatives to provide insurance facilities. As evidenced by the study, if there is a need, it should be met. In this field, we should be aware that there is a clear need and the commercial insurers (either by choice or due to constraints), have not been able to address this need to the desired levels, despite very clear enabling Government policies and persistent regulatory pressures during the last six decades.

Appreciating the difficulties in regulating multiple small organizations, the study recommends creating broad models of Self-Regulatory Organizations (SROs) with robust governance systems, accountability to the communities that they represent, transparency with the insurers with whom they do business, and responsibility to the society and the Government at large.

1. The study would therefore recommend the following actions:

i. Creation of legal empowerment for mutuals and cooperatives to operate preferably as IRDAI licensed entities or at least as “IRDAI Recognized Mutuals” or “IRDAI Recognized Cooperatives”. Only those willing to operate as per a specific regulatory framework would be licensed/recognized.

ii. Creation of macro level supervisory norms, providing for sustainable low capital models by creating prudential checks such as:
   - *i. Caps on sum insured.*
   - *ii. Defined customer segments and products/product lines.*
   - *iii. Linking exposure to entity level capacity.*
   - *iv. Create risk retention parameters with provision for reinsurance.*
   - *v. Insist on efficient governance systems, and transparent and macro level safeguards that conform to internationally best practices.*
   - *vi. Insistence on transparency to all stakeholders.*
   - *vii. Insurance should be a distinguishable major vertical.*
   - *viii. Participatory contribution by members is indispensable.*
   - *ix. In addition to participatory contribution, allow supplementary financing mechanisms including sponsored activity by insurers, who might find these models to develop new markets later on (eg DHAN Foundation’s rain gauge initiatives proved to commercial insurers that small rural farmers were also insurable).*

iii. Making reinsurance mandatory above specific thresholds of risk exposure – in terms of numbers and/or amounts. This would serve as an indirect operational supervision by reinsurers, who have exposure to multiple markets and global best practices.

iv. Allowing Indian insurers to reinsure mutuals and cooperatives up to certain threshold levels, above which reinsurers may provide cover.

v. Allowing only those insurers who are interested in this market to directly engage with this segment of customers. (It should not be made compulsory for insurers to operate in market segments that they are not interested in.) Allow insurers to achieve their mandatory Rural and Social Obligations (RSO) by reinsuring mutuals and cooperatives. This would help them cover the prescribed number of lives, without straining their resources in areas where they do not have a footprint, appetite or competence.

vi. Creating (as an alternative) a specific company (or a pool/wing under the National Reinsurer) which will reinsure all the rural and microinsurers including; life, credit, cattle, crop, poultry, agricultural pumps, beehives, bicycles, agricultural implements etc.

Although the study recommends regulation, recognition or specific exemption for MCCOs, in case that this is not possible, the Government may broadly state that those who fulfil the following criteria would be exempt from the scope of insurance and related regulations;

i. dealing only with their members;
ii. having specific affinities such as location, trade etc, which help in relationship-building;
iii. bearing their internal risks themselves;
iv. engaged in doing only certain specific activities;
v. not engaged in doing certain specified activities;
vi. maintaining transparent and robust systems for self-regulation and governance;
vii. having members from the community as part of their governance boards;
viii. having community-based claims settlement systems; and
ix. needs-based risk reduction.

The study finds that there is a strong case for providing financial, legal and capacity building support for mutuals and cooperatives working for the marginalized sector.

The study defines MCCOs as follows; *"An MCCO, in the Indian context (or elsewhere) should be founded on mutuality and have a strong mutual ethos. Its organizational structure and insurance like operations should be for the protection needs of the marginalized population that forms the bulk of its membership. It should have a community ownership and be governed, owned and run with member participation. It should have regular engagement with its members and designed for long-term financial sustainability."*

This study also recommends that the donors may adopt the following criteria while selecting beneficiary organizations (preferred models) to receive support:

a. Non-alignment:

Institutions should not be aligned to any overarching cause other than providing community-based benefits. They should be primarily supporting communities and providing community welfare using insurance principles for managing their financial risks. Donors should realize that the first few members would be seen as the flag bearers of this movement in India and with due respect to all the players in this space in the country, the Indian Government, the regulator and ICMIF would like to err only on the right side in supporting this movement, especially the pioneers of the movement.

Organizations that are directly or indirectly associated with any religious, political, communal, anti-social, anti-national or criminal affiliations might degenerate into carrying forward the agenda of those entities rather than that of the community and hence may not be the ones that the Indian Government, the regulator, ICMIF or donors would like to support. Even those who appear to be doing so as per the media or public perception may not find favor as the flag bearers.

b. Priority sector focus[34]:

There should be a clear focus on serving the low-income population and creating products which have customer value. Products should meet the demands, needs and aspirations of livelihood protection and livelihood enhancement at the community level.

Mutuals mostly respond to market failures or the unaddressed needs of the low-income, the poor, and the unorganized and excluded in any country. As such, institutions that are willing to provide such products or extend such products to these segments may be given priority for donor support.

c. Need-based products:

Products should enhance livelihood options of the target segment(s) and/or protect them from vulnerabilities, based on their needs or social/environmental conditions. Merely replicating insurance products sold by insurance companies like life, personal accident or credit life (that are generally available in aplenty) are not considered as priority, unless these address specific needs that are not addressed by such products.

Though such products/community services may not be called insurance as per the prevailing legal definitions in the country, the main products and services provided by the mutual should be based on the mutual insurance concepts of (i) pooling and sharing financial risks under mutuality or solidarity principles (and not transfer of risks), (ii) clarity on indemnity or benefits arising out of death, disease or accident, (iii) equitable prior contributions of money for the benefit, (iv) clarity and simplicity of conditions concerning when and how claims would be payable, (v) transparent systems for paying the unfortunate and receiving acquittal, (vi) community participation in managing the entire system; and (vii) systems to ensure sustainability of the scheme.

d. Risk reduction measures:

There should be a commitment to invest in risk reduction. Since mutuals are driven by member needs, there is an inherent need to focus on the risk reduction aspects of the product. Institutions that are willing to invest in long-term risk reduction and demonstrate their commitment to build sustainable products once they are mature will be given priority.

e. Scalability and sustainability:

A clear business plan and performance indicators for the scalability and sustainability of mutual risk sharing products is recommended. Amongst other things, donors should appreciate that the Indian Government, the regulator and ICMIF would like to promote only financially sustainable models, as per tangible evidence. At least in the initial phase, support should be restricted to those organizations that have clear plans to scale their projects and make them sustainable for low-income segments over a period of three to five years. Donors may not look at providing charity support to organizations in the long run but may seek out sustainable models that are professionally managed and run. Members who are presently receiving external financial support should present concrete board-approved plans, evidenced by financial statements as to how and when they would be breaking even and becoming self-sustaining. Organizations seeking support in any form would have to demonstrate a professional approach to the mutual scheme and readiness to implement widely accepted performance indicators as a measure of growth and maturity.

[34] The term “priority sector” refers to persons identified as economically weak (eg below the poverty line) or socially backward (eg “scheduled castes”), those geographically detached from the rest of the society (eg “scheduled tribes”) and rural areas of the country by the governmental authorities. In the limited context of ICMIF 5-5-5 Strategy, the term is used in a broader sense and may include broader sections of society such as migrant labourers, nomads or those marginally above poverty line, as long as these are defined in an objective and transparent manner.

f. Governance track record:

Organizations selected for support should have a proven track record of member-owned community-based systems with good governance.

While there are many community-based formats or MCCOs (as termed by the IAIS), donors should understand that not every member institution may be well-governed. There is a reputation risk for all stakeholders in associating with such organizations. Even in markets where mutuals are well regulated, good governance is a concern. Organizations that are managed with the active involvement of their members and having a demonstrable governance system by its members that reflects mutual values should be given priority. Good governance implies among other things regular board meetings, democratic decision making, transparency and accountability in operations and management, and a clear flow of information to and from members.

g. Willingness for advocacy:

In India and similar markets where mutuals are still not recognized, there is a lack of clarity on providing mutual solutions (risk-sharing) in the priority sector space. The study recommends that both (i) advocacy for mutuals and (ii) support for starting or scaling the operations of existing mutuals, should go hand-in-hand.

As the evidence gathered would be effectively used for the twin purposes of (i) advocacy and (ii) supporting and augmenting mutual operations, organizations seeking support should demonstrate a strong commitment to advocacy as well. Hence, organizations who are already providing mutual solutions willing to scale and those in the community space and willing to start may be given priority.

h. Willingness to work for common goals:

There should be willingness to share data and experiences and learnings with the Indian Government, the regulator and ICMIF as well as to contribute in building an inclusive Mutual Insurance Knowledge Hub.

The organizations selected for support should be willing to document their experiences and learning journey and share it with the Indian Government, the regulator and ICMIF for building an inclusive Mutual Insurance Knowledge Hub. This could be used for achieving common and collective goals including advocacy and dissemination for the benefits of other markets.

ANNEXURE A:

Case study 1

Overview of Uplift Mutuals

Organization: Uplift India Association (UIA) more popularly known as Uplift Mutuals was established in 2004 is a pioneer of mutual risk retention in India or mutual microinsurance. Its operations are currently spread in two Indian states; Maharashtra and Rajasthan.

Uplift (through its eight associates) currently serves more than 200,000 individuals under a mutual risk retention model. Its main target group is daily wagers, laborers and underprivileged families. Initiated as an association for over a decade, Uplift has transitioned into a mutual accelerator that helps communities build their health risk pooling schemes through a "built operate transfer" route.

The Uplift model works like a true mutual where members play a key role in every part of the scheme right from design to delivery

Insurance model: Mutual or pure risk retention model for health

Reason for introducing mutual insurance: Uplift Mutuals started its risk retention model for health primarily based on the healthcare and healthcare-access needs of its members, who were not happy with traditional insurance products available to them. Uplift members wanted an impact on health, transparency in pricing and cover, and a say in product design. They also wanted to be a party to profits as well as losses. For them, getting the right healthcare at the right cost was an important part of health financing.

Geographical reach: Three districts across Maharashtra and Rajasthan (both urban and rural footprints)

Primary beneficiaries: Mostly women and their families, distributed through microfinance groups

Product(s): Hospitalization with an array of preventive and promotive health services

Mutual/community-based features unique to the model: Uplift follows an ecosystem model of risk reduction combined with risk sharing. Product processes and even claims are decided by communities themselves, risk is not transferred to a third party but retained, and there is an overall focus on risk reduction and good governance so as to make the program sustainable and impactful. While its mutual risk component is sustainable, it needs to subsidize it risk reduction services as these are long-term investments in making the model viable.

Organization's willingness to scale or start mutual insurance: Uplift has been working on a "built operate transfer" model for the past decade, and now wishes to launch its direct distribution model and scale up its risk retention model to over 400,000 new low-income families.

Number of current members/beneficiaries: 200,000

Major partners: TIETO for MIS, distributing MFIs, the ILO MIF

Brief overview

Uplift Mutuals is the flagship program of Uplift India Association. Established in 2004, Uplift set out to design and develop a risk retention or mutual model of providing health microinsurance to low-income families living in the slums of Pune and Mumbai and later progressed into providing such services in rural areas of Pune and tribal Rajasthan (Dungarpur). In Uplift's model mutual, solidarity values are embedded right from product design to claims settlement as members participate in all such processes and the risk is retained and managed by them directly. In addition, the focus on risk reduction is aimed at improving the health parameters of its members.

Uplift's target population are families in the unorganized sector of India (living in ghettos), mostly daily wage earners who generally have no access to social protection schemes. With a daily income of INR 33-390 (USD 2-6) for an average family of four, health is not their prime concern until a destabilizing event happens. While on one hand this leads the family into a further downturn financially and into further poverty (as they borrow or mortgage or sell to cover costs), on the other hand, timely access to quality care with reasonable prices remains a dream.

Insurance products in the market are out of their bounds because of high premiums, while government schemes by their very design, as they only include the BPL, exclude a large number of poor households. If some families are fortunate to have BPL cards from Government sponsored health protection schemes, they are always treated as end users who have no say in the design or delivery of such a scheme.

The mutual model of Uplift addresses this by reaching out to such families through its member organizations who provide small business loans to families. Upon enrolling as a member, the family not only shares its financial risks that may be caused due to health events but also gains access to prevention and guidance services and a multi-layered network of healthcare providers. For the first time, families get involved in a process of being able to manage their health. Uplift's focus on risk reduction and its ecosystem approach comes through its outpatient network, the health check-up camps, health talks, a branch referral and guidance facility, and a 24x7 helpline that provides members with options to manage their health under medical guidance. These risk reduction services aim to not only provide tangible health services needed by the poor, but also control the cost of care essential to sustaining the small ticket size of the premiums. Members save hundreds and thousands of their hard earned money thanks to risk reduction services.

Upon availing hospitalization, the members file claims that are first medically validated and then go to claims committee meetings for decision making. This is the most empowering part where the members decide how they spend the money they have together, to help one-another. This brings not just a sense of ownership to members, but has also helped make decisions that are fair and sound for the claimant and the fund respectively.

Uplift's mutual model has been adopted by communities across three districts in Maharashtra and Rajasthan and includes urban, rural as well as tribal areas. While in Maharashtra, Uplift works with slum dwellers and families in rural areas. In Rajasthan (in Dungarpur, where 80% of the population is tribal) Uplift is helping communities in tribal areas to set up health mutuals.

Uplift's target population are low-income families living in the slums, villages and tribal areas. Most of the policyholders are women who are encouraged to join the scheme with their families.

Uplift started out as an association of developmental organizations and has since partnered with many like-minded organizations who are interested in the mutual risk retention model. Uplift has partnered with InterAide (a French NGO) and MACIF (a French Mutual), who have been their closest collaborators. It has also worked with a Finnish IT major TIETO, who remain their software partner and have co-built Uplift's latest online software. It has also worked with the ILO MIF, which gave a consortium-led grant to make back office processes efficient.

Insurance program

Uplift model

The genesis of Uplift Mutuals lies in low-income borrowers' efforts to save the life of one of their fellow members, who had faced an expensive medical problem which resulted in members contributing to share the financial burden. Fate brought death to this poor fellow, and those left behind were struggling for money and still unable to save the life of their fellow member.

They decided to do something with this looming challenge and approached an insurance company whose executive listened to them patiently and offered some solutions which they could afford. The members realized they received hardly any benefit in being healthy, and could benefit only if they fall sick.

It was this challenge that motivated Uplift Mutuals a decade ago to begin their journey of setting up a health microinsurance scheme for the poor, which could provide them with not just meaningful risk management but would also include their needs as the main input, and their decision making as the core function.

There are four pillars on which the mutual model designed by Uplift works;

Inclusive risk sharing
For example, this includes one price for all ages (there is no age-entry bar). Product exclusions are validated by the community based on their context (eg normal maternity is covered in some communities), there is informed risk management (ie rationalized utilization of services), and there is also a focus on family enrolment to ensure that girls are not excluded.

People/community centered
At Uplift Mutuals people play the role of the decision makers, right from product design to the claims decision community via their elected representatives,

An elaborate education and communications process is built in to the entire scheme, which brings in a great amount of transparency and accountability. Community representatives are trained over a period of time which enables them to take claims decisions and run the scheme according to set rules and guidelines.

Technically sound
Uplift was one of the earliest schemes to have a dedicated desktop MIS (from 2004), which has enabled its communities to make responsible and rational decisions over the last decade. Uplift has developed one of the most detailed and granular levels of data over the last decade, which has helped refine its products and services in consonance with feedback received from communities. Data from the scheme has regularly been presented to community representatives and explained to them in the most lucid manner. Uplift has recently upgraded its MIS to a sophisticated web-based system (UTTAM) in partnership with TIETO, which has allowed them to bring greater efficiency in enrolment and claims management and an array of reports that will help communities better manage their mutuals.

Health services as an ecosystem and risk reduction mechanism
Over the years Uplift has been successful in creating a healthcare-access ecosystem that is not just restricted to making financial compensations to policyholders but also helps in raising awareness about healthcare through talks, camps, shows, training programs etc. To keep the cost of healthcare within manageable limits for members, Uplift has provided a 24x7 helpline, access to qualified doctors and a multi-layered network of healthcare providers for quality care with concessions, along with localized referrals and guidance, and a systematic follow-up.

Mutual governance at Uplift

Uplift's operations are "pure mutual" where members/clients are also the owners, they take part in designing the product, the processes and are also the key decision makers when it comes to claims. As far as the governance is concerned, Uplift follows a standard design of electing a representative for every 2,000 policyholders for a period of one year.

A claims committee is set up which also acts as the governance body for the mutual units, unless the community is organized as a federation or a cooperative where the elected board members are de facto the claim committee members. Product rules, claim categories, coverage, sub-limits and exclusions are all technically designed by Uplift and validated by the community representatives. These mutuals are organized by each community, who elect their representatives which are responsible for running the scheme. These community members are trained by Uplift and are "hand held" till they become capable of making their own decisions.

Grievances if any are referred to the same committee for consideration. This system is currently working well with no escalation of complaints. Apart from minor teething troubles in the first year, there were no instances of complaints being escalated. It was observed that credibility in the approval system is built up during this period. Customers are made aware at the time of enrollment that their claims will be decided by their own representatives.

Performance indicators

Table 2: Proportion of low-income households in comparison with total portfolio	100%
Proportion of women insured as a proportion of the total insured	90%
Claims turnaround time (in days)	15 days on an average
Proportion of claims rejection	2-5%
Growth ratio	10% (previously up to 25%)
Claims ratio for 2012	78%
Claims ratio for 2013	58%
Claims ratio for 2014	65%
Renewal rate for past year one (location one)	(Pune and Mumbai two) 75%
Renewal rate for past year two (location one)	(Pune and Mumbai two) 73%
Renewal rate for past year three (location one)	(Pune and Mumbai two) 71%
Renewal rate for past year three (location two)	(Rajasthan three) 97%

The key challenges

In this field, the most important challenge faced by any institution in India is the lack of appropriate regulations. Mutual insurance is not formally recognized by the insurance regulator IRDAI. One thing that has probably saved this sector from the presence of unscrupulous players is the lack of financial incentives. Health insurance is mostly a loss-making proposition unless there is a strong emphasis on preventive healthcare and reasonable checks on moral hazard related issues. Mutual health segments also need strong IT backup and financial resources which are not easily available, and without reaching a minimum scale size there are issues of sustainability.

India is one of the least penetrated insurance markets, which says a lot about the general apathy towards the availing insurance facility. There are other strong reasons as well that keep many out of the ambit of insurance. For example, certain communities do not come forward for insurance, as they believe that the insurance services on offer are not as per their religious ethos.

Replication and expansion plans

Uplift is currently incorporated as a not-for-profit company where pooling of members' risk beyond a limit is not possible. To address this challenge, Uplift has adopted a partner/associate model where risk-pooling normally happens at the associate(s) level and all other services are managed and provided by Uplift. Normally these associates are MFIs. These MFIs do not have a wide coverage due to either lack of capability (ie financial and/or human resources) or due to strong competition. Microfinance regulations in the country are also fluid and provide much scope for regulatory arbitrage.

Uplift's operational model has been what can be termed as "built operate transfer" where it built mutuals with microfinance organizations, operated along with these mutuals and then transferred the entire know-how to these organizations. The first of such transfers happened in 2012 and by 2015 most of the work has been transferred to partner organizations by Uplift.

In 2014, upon reviewing Uplift's decade long work, the management of Uplift came up with certain interesting learnings:

1. Distributed primarily through microfinance, the mutual product could not be accessed by those not wanting loans or were above 60 years of age (Uplift's women members asked them many times if they will get the product when they need it the most, since loans are not given to those above 60 years of age).

2. With every community (there are nine of them), Uplift generated a new learning curve, which was inefficient in terms of time and resource, since they were working with a "built operate transfer" model.

3. Uplift tried pooling different risk pools into one, so as to spread the risk (they planned to create a solidarity fund), make it more diverse and bring efficiencies of scale, but since their mutual units were organized along microfinance partners (and were competitors there) it never came through, keeping the risks pools small and hence vulnerable to co-variant risks.

4. Uplift found that with their partner MFIs the focus and priority remained their credit operations and over a period of time mutuals were governed more on the credit operations based exigencies or compulsions. Uplift decided that in future credit and insurance should be kept and managed separately.

5. On the other hand Uplift found that their existing services (including dedicated out-patient departments, 24X7 medical helpline, preferred provider network, and preventive health program) had the ability to act as a point of aggregation provided they ramp them up from their current state. These services have helped Uplift in providing a high client value product and could act as a rallying point.

6. Uplift understood that due their limited health services approach we could not provide full-fledged out-patient departments or medicines where most of the out of pocket expense happens.

To overcome these challenges, Uplift decided to change its operational model to B2C where it could directly pool risks of communities and make it open to work with non microfinance groups and communities. Uplift plans to intensify its health services approach in order to reduce its risk of working with non-microfinance voluntary groups and also provide outpatient services where most of the out-of-pocket expenses are taking place.

Case study 2

Overview of People Mutuals (DHAN Foundation)

Organization: People Mutuals was established/registered as a trust under the Indian Trusts Act in December 2003. It is a mutual microinsurance initiative facilitated by DHAN Foundation and operates as a "federation of federations"

Insurance model: Mixed (large proportion is partner-agent, a smaller proportion is mutual)

Reason for introducing mutual insurance: To offer products which are not covered through social security schemes, or market products

Geographical reach: DHAN Foundation works in 51 districts across 13 states in India and has promoted about 190 federations. Out of these, 86 federation mutuals have been registered to manage their microinsurance operations as subsidiaries of the federation

Primary beneficiaries: Mostly women and their families across federations, men, tribal communities, and youth

Product(s): Health, crop, life and livestock

Mutual/community-based features unique to the model: The mutual contracts of DHAN Foundation/People Mutuals are essentially mutual-help programs, to cover the risks of the poor that are not covered by mainstream insurance companies.

The number of mutual insurance contracts under the various mutual models was 216,445, of which 136,717 were in health. Low-income policyholders paid a total premium of about INR 110,730,000 (USD 1,703,538) for insurance covers, with the sum insured around INR 53.5 billion (USD 823 million)

Organization's willingness to scale up, or start mutual insurance: DHAN Foundation has been innovating and reaching out with new products over the years, including life, health, livestock, crop insurance and insurance for people living with HIV

Number of current members/beneficiaries: 1,274,932 poor are covered under partner-agent products and mutual solutions. Of these, 216,445 are beneficiaries of mutual solutions

(Source: Latest published figures available in public domain - as of 31 March 2013).

Major partners: Oxfam Novib, Rabobank Foundation, Achmea Foundation and Micro Insurance Association of Netherlands (MIAN)

Description of the insurance program

Community health insurance and integrated healthcare model[35]

DHAN Foundation's integrated healthcare and insurance programs convert personal expenditure into social expenditure through the pooling of risks by communities.

Origins of DHAN Foundation's mutual health insurance program

A study conducted by DHAN Foundation in 1998 revealed that the healthcare expenditure of their member families was about 20% of their household income, which they met by borrowing from different sources. The credit portfolio of the self-help groups (SHG) themselves accounted for 15%. (Needless to say, commercial insurers were not interested in the micro requirements of such a micro segment of the market, which would not generate enough premium income even to meet the expenses of issuing the policy.) The KKVS Federation decided to address this situation and initiated a primary care clinic in the year 2000, and also started a community health pilot with about 3,000 low-income families. This involved providing a health insurance policy of INR 10,000 (USD 154) for a contribution of INR 150 (USD 2.3) for a family of five, including the wife, husband and children. The program involved reimbursement of 75% of hospitalization expenses at selected hospitals in Kadamalaigundu and Theni, where KKVS pre-negotiated the terms and prices of the services through a memorandum of understanding. Inspired by the success and benefits of the community health insurance pilot, similar programs were initiated by four more federations of SHGs in the district. Issues in getting optimum service from certain private hospitals paved way for the establishment of community federation clinics for primary care, and community hospitals called "Suham" hospitals at Theni, Madurai and Salem. The program resulted in enhanced health-seeking behaviour, health insurance awareness, and access to healthcare.

[35] Integrated Healthcare and Insurance – A community model, Rajapandian R, Chief Executive, SUHAM Hospital Trust, Sivarani B, Program Leader, DHAN Foundation.

Transition from mutual to provider, plus the health insurance model

The Government-owned National Insurance Company (NIC) came on to the scene during 2006 with a tailor-made insurance product especially for DHAN Federation, which involved primary care services from Suham hospitals with 25% co-payment and reimbursement of 75% of hospitalization expenses at selected hospitals.

The establishment of the community federation clinics and Suham hospitals as healthcare service institutions caused community health insurance to evolve into a provider model of community health insurance, arguably making the insurance proposition viable for NIC. The program is presently implemented in the Madurai and Salem districts of Tamil Nadu, India.

DHAN Foundation also offers crop risk protection for rural farmers who cultivate their crops on small farmlands. With the help of the International Labour Organization's Microinsurance Innovation Facility (ILO MIF), People Mutuals set up a dense network of local automatic rain gauges (with an average distance of five kilometres between the rain gauges) in the state of Tamil Nadu and Andhra Pradesh in India. DHAN Foundation's experience in a number of villages since 1990, and the work of People Mutuals' since 2003 in providing life insurance to its members, came in handy and People Mutuals' farmers became involved in the process of installation, design and the supporting processes of the rain gauges.

The prevailing institutional structure for the delivery of insurance was based on small local mutual pools organized through federations of farmers' groups. As these local pools were too small to handle crop losses, People Mutuals initiated a mutual catastrophe system across various locations that diversifies risk over two states. Reinsurance support for the program was provided in 2010 by transferring the risks to the Agriculture Insurance Company of India Limited (AIC).

The Government crop insurance scheme, National Agriculture Insurance Scheme (NAIS), operates on the basis of both a "regional approach" for widespread calamities, and an "individual approach" for localized calamities such as hailstorms, landslides, cyclones, floods etc with a 50% subsidy for small and marginal farmers. The subsidy is shared equally by the Government of India and respective State Governments, and the "VarshaBima" a rainfall index product used by the AIC, are available to them. As per a number of studies, in locations with access to the NAIS the price dimension appeared to be an important motivation for take up of the NAIS as it is subsidized by the Government. However, access to the NAIS is not considered uniform and claims settlement is not always perceived as transparent by farmers. The characteristics of the mutual model, such as involvement of farmers in product design, increased the value of the product. Many farmers are able to distinguish that weather index insurance insures weather risk and not crop growth risk. Though the additional value by way of price reduction could not be ascertained, trust building would imply the affordability of the product and a better product experience, especially because of the farmers' involvement in claims settlement.

On the access and experience dimensions, farmers involvement in education, marketing, sales and claims settlement has contributed to building trust in the insurance mechanism, on rain gauges as an acceptable index and a better understanding of claim payments.

Table 3: Products

7.1 Type of insurance *	7.2 Total risk cover	7.3 Premium amount	7.4 Geographical Outreach (Name of states or districts covered)	7.5 Outreach (Number of lives covered)
Life	INR 56 billion (USD 865 million)	INR 28 million (USD 431,000)	Tamil Nadu, Andhra Pradesh, Karnataka, Puducherry, Maharashtra, Odisha, Assam, Bihar, Rajasthan, Madhyapradesh	750,000
Health	INR 2.8 billion (USD 43 million)	INR 42 million (USD 646,000)	Tamil Nadu, Andhra Pradesh and Karnataka	350,000
Livestock	INR 1.28 million (USD 197,000)	INR 510,000 (USD 7,850)	Tamil Nadu, Andhra Pradesh	6,400
Crop	INR 1 million (USD 15,400)	INR 250,000 (USD 3,850)	Tamil Nadu	500

(* life insurance, health insurance, livestock insurance, crop insurance, credit-life, weather insurance, composite products)

Case study 3

Overview of The Goat Trust

Insurance model: Pure mutual

Reason for introducing mutual insurance: Problems with livestock insurance offered by mainstream insurers. No insurance was offered for smaller livestock such as goats; a high moral hazard makes the premium unaffordable

Geographical reach: Primarily in Uttar Pradesh, but with the potential to scale up to 13 states

Primary beneficiaries: Low-income families

Product(s): Livestock (goat) insurance

Mutual/community-based features unique to the model: Risk reduction along with community-owned risk management under the mutual model for livestock insurance, success in a model where commercial insurers have traditionally failed

Organization's willingness to scale up, or start mutual insurance: Plans to scale up its current model and offer health products in partnership

Number of current members/beneficiaries: 7,000 insured livestock but potential to scale up to 100,000 farmers

Major partners: Donors like TATA TRUST, NRLM, SLRM etc

Brief overview

The Goat Trust is registered as a charitable trust to promote small livestock (such as goats, sheep, backyard birds rearing) based livelihood through demystifying production technology, building institutions and promoting a standard of marketing and linkage across the globe. It is mandated to grow as a resource organization to work on the development of pro-poor small livestock farming systems, technologies and market development through collaboration and networking with various stakeholders.

The Trust was registered in the year 2008 and is managed by professionals. Technical services include developing and providing productive breeds of goats, medical care and first aid for goats, building of goat houses, and the development and procurement of livestock feed for goats. Financial services include the arrangement of microcredit for goat farmers, and developing and monitoring community-based insurance schemes for goats. Management services include the development of a MIS system. All this is done through the creation of Goat Rearing Groups (a type of community-based organization) and their federations.

The portfolio of services provided by The Goat Trust includes technical support, financial services and management services. The Goat Trust has also diversified into related verticals which includes microcredit, microleasing, and livestock credit cards.

All the services are offered to goat farmers through NGO/CBO partners, including training of Pashu Sakhis (veterinary nurses) and Community Livestock Managers (CLM). Both the Pashu Sakhis as well as the CLMs are given extensive training and a model for sustainability.

As of now, various components of the program touches almost 125,000 goat farmers across 14 states in the country.

As a part of the financial services package, the partners are also offered a community-based insurance scheme for goats. The scheme works purely on a mutual basis and no commercial insurance providers are involved.

Insurance program

As indicated earlier, The Goat Trust facilitates the creation of a community-based insurance program for goats. The organization believes in customizing the program to the needs of the local communities and hence there is no standard product for their schemes.

Before launching the insurance program, the structure of Pashu Sakhis is strongly put in place. Baseline studies are carried out to assess the normal mortality levels before any interventions are made. Once the mortality rate is established and reasons for mortality are mapped, an aggressive risk reduction program is undertaken with an objective of reducing the mortality rate. It has been observed that because of risk reduction measures like immunization, doorstep primary medical care and proper food intake of the livestock, mortality rates have come down from as high as 28% to under 5% over a period of time in various project areas.

Following these risk reduction interventions, once the mortality rate has stabilized, the issue of insurance is taken up with the communities. Intensive training on the concept of insurance is undertaken. The readiness and the capacity of the communities to take up community-based insurance is assessed. The program is launched only if sufficient numbers of farmers are ready to enroll their livestock for insurance. This community-based insurance is thus purely voluntary.

Based on the reduced mortality rate as a result of risk reduction measures, the premium rate is calculated. Full indemnity is avoided even in the case of death of the livestock. Due to this the premiums can be kept under affordable limits on one hand and on the other insurance does not become a disincentive for risk reduction measures or a tool to promote moral hazard.

It is understood that the fund created through premium collection is kept with the community only. A well-trained claims committee is constituted from within the community, who then dispose of the claims that arise during the currency of coverage.

There have been a number of lessons learned from such a community-based model. Firstly, a strong focus on risk reduction from within the community makes the scheme sustainable, apart from bringing down the overall mortality rates and thereby the claims incidence. Since the insurance scheme does not work in isolation but is combined with the overall goat-centric livelihoods, adverse selection and moral hazard can be overcome to a great extent. The schemes have been able to maintain mortality rates of below 5% in almost all project areas thereby keeping the claims ratios and premium rates stable. Secondly, the cadre of Pashu Sakhis and the entire support system becomes accountable for tangible outcomes as a result of community-based insurance. Insurance also makes active involvement communities possible. Thirdly, insurance also becomes a critical determinant for the demand for regular vaccination and deworming initiatives thereby creating a pull for these services.

In regards to the challenges, the existence of a strong SHG network becomes a prerequisite for the generation of desired volumes as well as effective management of the insurance program. Continuous training, capacity building and support services are the key success factors for community-based insurance. Since these activities need to be continued over a period of time before the communities can become self-reliant, this involves cost. This becomes a critical factor from the viewpoint of the scalability of the program.

Replication and expansion plans

As is the case with any other mutual insurance program, the absence of regulatory recognition is one of the important factors affecting scalability of such programs. The nature of the risk (livestock) being underwritten by such schemes also involves the possibility of a catastrophic loss as a result of natural calamities. In such cases, it is quite possible that the small pool created from premiums paid by the community cannot fulfil the claims obligations under the scheme. This gives rise to the need for some kind of reinsurance support for these schemes. Since the mainstream insurance industry is unlikely to support such mutual arrangements, an alternative way of risk pooling among these schemes has to be worked out.

The organization wants to upscale this community-based livestock insurance program to many more livestock farmers across the country. It also has the necessary expertise, experience as well as the data to do so. Funding of start-up costs on setting up the programs and capacity building could be a major limitation here. Moreover, since the insurance program cannot succeed in isolation, the entire basket of services has to be rolled out, which again adds to the cost of starting the program. The time taken before decent volumes can be built could be sizable. The Goat Trust also wants to offer health insurance to its farmer members.

The Goat Trust's Goat Mutuals have been adopted by the Government of Jharkhand and the Government of Maharashtra, which gives immense potential to scale up.

Case study 4

Overview of VimoSEWA

Insurance model: Mixed (large proportion is partner-agent, a smaller proportion is mutual)

Reason for introducing mutual insurance: A study undertaken by the Self Employed Women's Organization (SEWA) in the early 1980s to analyze the reasons behind credit defaults among SEWA Bank borrowers showed that many defaults were due to death or sickness in the family. This prompted SEWA Bank to look at insurance to provide risk management opportunities to female borrowers.

Over a period of time VimoSEWA realized that with mutual insurance they could provide a better insurance service experience and value to end-users, and hence decided to venture into the insurance sector

Geographical reach: Partner-agent products offered in Gujarat, Rajasthan, Madhya Pradesh, Delhi and Bihar, with a mutual product only in Gujarat

Primary beneficiaries: Female workers of the informal economy

Product(s): VimoSEWA offers products such as health insurance, life insurance and credit life insurance through the partner-agent model, in partnership with the Life Insurance Corporation of India (LIC), L&T General Insurance Company and the New India Insurance Company. VimoSEWA also designed a mutual health insurance product offering a daily hospital cash allowance

Mutual/community-based features unique to the model: The mutual health insurance product offered by VimoSEWA focuses on the livelihood of the members. Basic hospitalization for members is covered under government schemes such as Rashtriya Swasthya Beema Yojana (RSBY), as members are below the poverty line. The VimoSEWA model provides a daily cash allowance of INR 200 (USD 3.1) during hospitalization, which covers loss of wages

Organization's willingness to scale up, or start mutual insurance: VimoSEWA is keen to scale up operations and move into a fully-fledged mutual model if the legal environment and back-end reinsurance support is in place

Number of current members/beneficiaries: VimoSEWA has more than 60,000 members for the partner-agent model and 5,214 members for the mutual model

Major partners: VimoSEWA has partnered with all SEWA sister organizations from different states, ie Delhi, Madhya Pradesh, Bihar and Rajasthan. VimoSEWA also has partnered with NGOs such as LokBiradari Trust, Supat Foundations, Srijan Livelihood and Daya Society etc

Brief overview of the organization

The Self Employed Womans Association (SEWA) is a trade union, registered in 1972. It is an organization of poor, self-employed women workers. These are women who earn a living through their own labour or small businesses. They do not obtain regular salaried employment with welfare benefits like workers in the organized sector. They are the unprotected labour force of our country. Constituting 93% of the labour force, these are workers of the unorganized sector.

Shri Mahila SEWA Sahakari Bank Limited (SEWA Bank) was one of the early ventures set up to offer savings and credit facilities to SEWA members. A study undertaken by SEWA in the early 1980s to analyze the reasons behind credit defaults among SEWA Bank borrowers showed that many defaults were due to death or sickness in the family. This pointed to the need of insurance for these borrowers.

Low-income households were not the target area of the Indian insurance sector. SEWA convinced LIC to offer "credit life insurance cover" to SEWA borrowers in 1992. This resulted into the formation of VimoSEWA. Vimo means insurance in Gujarathi, and as the SEWA organization has roots in Gujarat the name was selected for the insurance arm.

Based on feedback from members, VimoSEWA introduced voluntary life and accident, voluntary asset and voluntary health cover, plus an extension of cover to the spouse and children of members. In 1999, private insurance companies were allowed to start up business in India which also prompted SEWA to create VimoSEWA, a separate entity. VimoSEWA became operationally separated from SEWA Bank and part of SEWA's social security team.

Description of the insurance program

VimoSEWA's mixed model for microinsurance

VimoSEWA has experimented with different product mixes over the years, starting from stand alone products in the 1990s to offering bundled products post-2001. This product mix includes life, health, accident and assets with standard sums insured.

Table 4: VimoSEWA's mixed model of microinsurance products

Product name	Product features
Swastha Parivar 1	Family floater health insurance covering families of up to 2+4 members for a maximum of INR 10,000 per year (USD 154)
Swastha Parivar 2	Family floater health insurance covering families of up to 2+4 members for a maximum of INR 25,000 per year (USD 385)
Sukhi Jeevan 2	Individual life insurance for INR 10,000 (USD 154) without return of premium
Sukhi Jeevan 3	Individual life insurance for INR 30,000 (USD 462) without return of premium
Jeevan Madhur	Savings linked life insurance with death benefit ranging from INR 3,000 (USD 46) to INR 30,000 (USD 462) with return of premium and bonus. Policy term can be from five to 15 years
Credit Life	Life insurance covering the loan amount. Issued to banks and MFIs
My Jeevika - PA	Accidental death and permanent total disability for INR 50,000 (USD 769)
My Jeevika - Hospital Cash	Fixed daily allowance of INR 250, 500, 1000 (USD 3.8, 8.0, 15) for every day of hospitalization up to a maximum of 30 days in a policy year. Policy covers individuals only
Saral Surksha Yojna	Family floater policy covering a family of up to 2+2 offering a daily allowance of INR 200 (USD 3.1) for every day of hospitalization for a maximum of 15 days in a year. Also covers accidental death of the primary insured (woman) for INR 100,000 (USD 1,538) and their spouse for INR 50,000 (USD 769)
Sukhi Parivar 1	Integrated product covering health for INR 2,000 (USD 31), life for INR 10,000 (USD 154), accidental death for INR 25,000 (USD 385) and assets for INR 10,000 (USD 154), Available on an individual as well as family basis

Table 5: Insurance membership over the years

Year	Total insured
2013	92,345
2012	101,061
2011	99,117
2010	119,477
2009	107,398
2008	195,449
2007	214,181
2006	178,202
2005	129,279
2004	106,479
2003	112,112
2002	92,928
2001	90,259

As VimoSEWA is a member-based organization, all commercial as well as non-commercial activities of SEWA have revolved around grassroots-level insurance promoters called "aagewans".

These are enterprising women drawn from the community and trained for this particular activity. In the context of VimoSEWA, aagewans constitute the frontline sales force in the direct marketing team. These women, like agents of insurers, go from house to house to promote insurance and enrol members.

Mutual component

VimoSEWA offers mutual health insurance in the form of a daily cash allowance product. The total risk of this product is on the books of VimoSEWA. The product design is done with the help of an external actuary, and for policy servicing they have also developed their own IT software. VimoSEWA also provides guidance to other organizations who are interested in mutual insurance through a program called VITAS[36].

VimoSEWA's experience with mutual insurance

The mutual insurance product provided by VimoSEWA is based on risk sharing. The current product is inadequate due to medical inflation. In the absence of regularity support, no reinsurance is available and carrying the risk on its own makes customization of the mutual product a challenge for VimoSEWA.

The major reason for emphasis on mutual insurance is the direct control on the servicing of insurance claims. In the case of traditional insurance companies, the typical claims settlement cycle varies from a week to a couple of months. For a poor family to arrange money for this duration is a challenge.

VimoSEWA has found that the average claims settlement time for the mutual model is just 10 days compared to 30 days under the normal partner-agent model.

The customization of products as per the requirements of end users is possible for mutual insurance; for other insurance policies the customization may or may not go down well with the insurance company. VimoSEWA's mutual model was started in 2009. Even today less than 10% of lives are covered under the mutual model, while all other lives are covered under the partner-agent model.

VimoSEWA has a dedicated customer care department which serves customers of mutual insurance as well as insurance customers of the partner-agent model. This customer care department is responsible for all the grievances received on phone or through walk in customers. VimoSEWA also conducts weekly or fortnightly meeting with all Vimo Sathis and Aagewans (sales persons) who are directly in touch with end users to provide an update on the grievance redressal mechanism or to address complaints.

[36] In October 2009, the National Insurance VimoSEWA Cooperative Limited established VimoSEWA's Insurance Technical Assistance Services (VITAS) in order to provide technical support and partnership in the field of microinsurance.

Business case of the model (source of funding/financial sustainability)

- VimoSEWA's mutual program is sustainable at the current level of coverage they are offering. Where as to scale it further in terms of georgraphical reach or providing the higher coverage value there is no backend support available.

- VimoSEWA strongly feels that instead of one time support in the form of a grant to make mutual insurance more sustainable, the regulator needs to recognize mutual insurance legally so that reinsurance support can be sought by mutual insurance providers and the program can become self sustainable in the long run.

What are the key challenges/risks faced

- One of the key challenges faced by VimoSEWA is the absence of legal or regulatory recognition, which makes obtaining reinsurance support from India or abroad very difficult.

- As the complete risk is carried by VimoSEWA, in the case of an eventful year, the books of VimoSEWA may get completely wiped out.

- Low insurance awareness amongst members is also one of the key challenges faced by VimoSEWA.

Replication and expansion plans

- For the expansion of its existing mutual insurance model, VimoSEWA would like to have reinsurance support and recognition from the IRDAI.

- Sister organizations of SEWA are interested in replicating the VimoSEWA model (where as due to lack of clarity VimoSEWA has put their expansion plans on hold).

- VimoSEWA is planning to introduce various health insurance products and some asset insurance as a mutual insurance product in the future, if they receive the required support.

- VimoSEWA is open to support from ICMIF in the form of reinsurance support and other technical know-how to scale up their existing activities.

Case study 5

Overview of the Society for Elimination of Rural Poverty (SERP)

Insurance model: Government-run insurance scheme, with a partner-agent and mutual insurance model

Geographical reach: All of Andhra Pradesh and Telangana (around 6.8 million women members)

Primary beneficiaries: Women members of SHG federations, and their families

Product(s): Cattle insurance (under the mutual model), and credit insurance is also offered through a sister organization

Mutual/community-based features unique to the model: Unique model of SHG federations supported by the State Government, which offers both partner-agent model products and (in some instances) mutual products

Number of current members/beneficiaries: 110,000 in cattle Insurance, and 50,000 in credit insurance

Organization's willingness to scale or start mutual insurance: Open to the idea but no specific plans at present. This is because they are in a phase of change and realignment as the State splits into two separate States – Andhra Pradesh and Telengana

Major partners: Government of Andhra Pradesh and Telangana, and other government/semi-governmental bodies

Brief overview of the organization

The Society for Elimination of Rural Poverty (SERP) started in 2006 with the belief that disadvantaged communities could be empowered to overcome all social, economic, cultural and psychological barriers through self-managed organizations. The primary beneficiaries of SERP are people living below the poverty line.

In 2006 Chittor, Karimnagar and Nizamabad districts approached LIC independently for life and disability insurance, and availed of this facility for two years.

This in turn inspired SERP to start a similar facility and introduce life and disability insurance in April 2008 across the state of Andhra Pradesh. After the split of Andhra Pradesh into Andhra Pradesh and Telangana, the organization has also divided into two seperate units; one for each state.

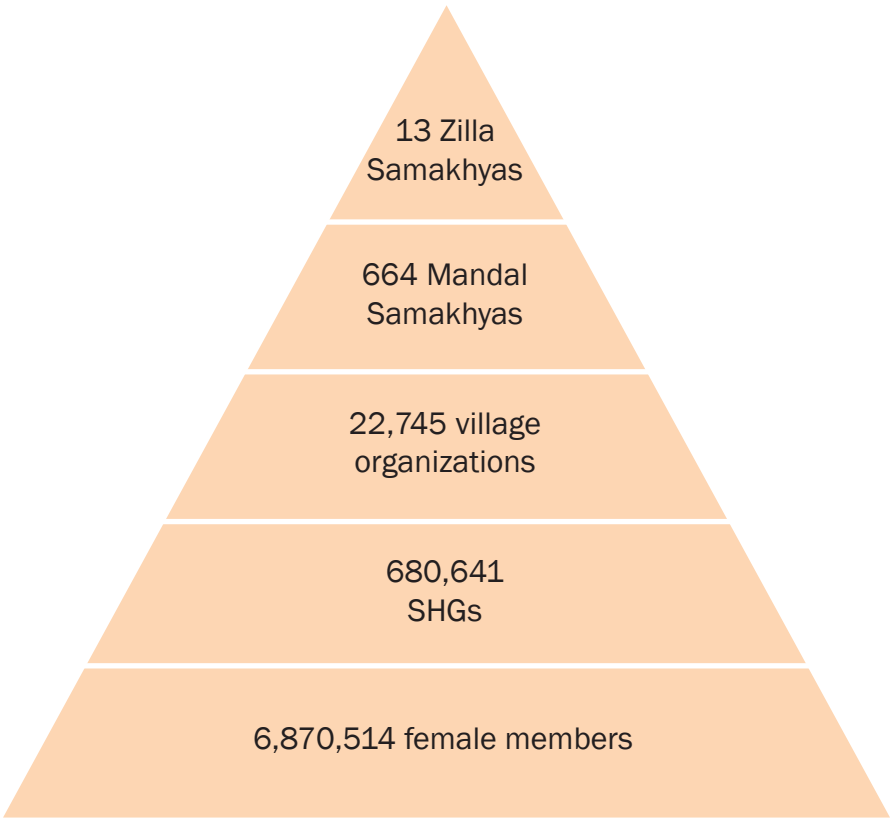
There are various kinds of insurance policies currently run by both states.

- Aam Aadmi Bima Yojana (AABY)
- Anna Abhaya Hastham
- Loan insurance
- Social security pensions (SSP)
- Livestock insurance (in some districts)

Organization structure

The organization is structured as follows with all the members elected from SHGs.

Figure 17: Organization structure for SERP



The base level of the organizational structure starts with SHGs of 10 members. 10 SHGs are in turn clustered into village organizations, and then clustered further into Mandal Samakhyas and Zilla Samakhyas.

Insurance programs

SERP has a number of social security schemes implemented under the partner-agent model. However its federations, in some districts, offer two products under the mutual model.

Mutual products

Livestock insurance
Cattle insurance started in Vijaynagar in 2010-11 as a mutual insurance product with a premium of INR 5 per INR 1,000 ie USD 0.1 per USD 15.4 (this was the average premium charged by various insurance companies).

15 districts including Vijaynagar approached United India for livestock insurance with a premium of INR 4 per INR 1,000 (USD 0.1 per USD 15.4). The claim ratio was more than 100% for United India and the company increased the premium to INR 4.5 per INR 1,000 (USD 0.1 per USD 15.4).

Vijaynagar decided to move back to the mutual basis with their earlier premium of INR 5 per INR 1,000 (USD 0.1 per USD 15.4) and the claim ratio has now reduced to below 90% for the district.

Loan insurance: Stree Nidhi Telangana

Stree Nidhi is a sister organization of SERP, and started as a credit cooperative federation in 2011. Stree Nidhi was created by Mr GVJ Reddy, who is a retired National Bank for Agriculture and Rural Development (NABARD) banker.

Stree Nidhi operates through a mobile model and maintains records in electronic form rather than physical. Stree Nidhi also operates through insurance call centres for claim settlements.

Stree Nidhi offers deposit schemes like the Samriddhi five year deposit scheme as well as the Sankalp recurring deposit scheme to which the SHGs have to compulsarily subscribe.

Interest-free loans are also offered to SHG members with the State Government providing interest subvention. The loan application process is through an Interactive Voice Response System (IVRS) with messaging services across telecom operators. The loan requests are made during the SHG/village oganization meetings which are held once a month. Loans are sanctioned within 24 hours and disbursed within 48 hours.

LIC used to provide insurance services for these loans. **Since 2014 the risk of the life insurance loan is borne by Stree Nidhi. The life insurance risk of the loan is provided for individual life as well as livestock.**

Stree Nidhi charges a premium of 0.4% for covering the risk of the loan and has a 93-95% loan recovery rate.

The call centre is common for both insurance and Stree Nidhi.

Impact of the model

The key impact of these models has been a change of mindset, with lesser dependence on pawn-brokers as well as other informal micro-finance institutions.

This model has also reduced out-of-pocket expenses for members, as well as improving the risk management of the target households.

NGOs and traditional insurance providers take time to convince the different stakeholders, but SHGs are more effective in communication and dissemination of this information across community members. SHGs have also been able to penetrate insurance awareness messages across illiterate members.

Special features of the insurance program of SERP

SERP has implemented stringent proceeses and has in-house IT software systems as well as product designing capacities. SERP provides a call center facility for claims registration and processing.

SERP also insists that only females can become SHG members. The SHG has different levels in the organization, and receives capability-building training from SERP.

As the insurance policies are renewed each April, the SHGs conduct meetings acrosss stakeholders and ensures that all policies are renewed accordingly.

The settlement of claims is currently carried out by Zilla Samakhya, which is completely community driven and has led to a reduction in fraudulent claims.

A social audit is committed by SERP, and in the case of fraudulent claims the village organization officer is removed. Societal pressure also ensures the recovery of funds from fraudulent claim. In some the cases, the declaration of social audit itself has led to recovery process. No risk is carried by SERP.

Business case of the model (source of funding/financial sustainability)

The model is currently financed through government grants, and any change in governmental policies affects the continuity.

Major reasons for success of the model

- SHGs are in a better position to communicate the benefits of this model and of insurance, as well as providing live examples to all the members concerned
- Outreach, due to significant size of the infrastructure, supported by the government
- The transparent cost structure of the model is one of the key atttractions for the cost-conscious consumer.

What are the key challenges/risks faced

- Financial resources of the State Goverment
- In the case of a change in goverment, the willingness of the new goverment to continue with these schemes
- Insurance awareness

Replication and expansion plans

Currently SERP have no specific replication and expansion plans. This is because they are in a phase of change and realignment as the State splits into two separate States – Andhra Pradesh and Telengana.

Case study 6

Overview of the ESAF Swasraya Multi State Cooperative Credit Society Limited (ESCCO)

Insurance model: Cooperative model, with both partner-agent and mutually aligned products

Geographical reach: Kerala, Tamil Nadu, Chhattisgarh, Madhya Pradesh, Maharashtra, Rajasthan, Haryana and Delhi

Primary beneficiaries: Members of ESAF, mostly women

Product(s): Health insurance

Mutual/community-based features unique to the model: The current mutual model of ESAF is more of a member welfare program and not a pure insurance mutual

Organization's willingness to scale or start mutual insurance: Plans to start a full-scale mutual insurance model, especially for health insurance

Number of current members/beneficiaries: 427,018 poor are covered under both general insurance and mutual solutions for credit life

Major partners: Not known

ESAF Swasraya Multi State Cooperative. Credit Society Limited (ESCCO) is a multi-state cooperative society registered under the Multi State Co-operative Society Act in October 2011, with presence in the states of Kerala, Tamil Nadu, Chhattisgarh, Madhya Pradesh, Maharashtra, Rajasthan, Haryana and Delhi. The main objective of ESCCO is to promote the overall economic betterment of members through financial inclusion in accordance with cooperative principles.

Organization structure

Figure 18: Organization structure for ESCCO

Minimum five and maximum 10 people can form a SHG (Self-Help Group)

↓

Five or six SHG together form a Sangham

↓

50 to 100 Sanghams form a cluster

↓

About four clusters are attached to every branch
From every cluster seven members are selected to form a committee in the branch
They act as branch advisor
There are total 220 branch offices across India
These clusters report to the corporate office

↓

From the SHG and these clusters, some members are selected to be representatives at the corporate office.

Insurance program

ESCCO is owned and controlled collectively by its members, who democratically elect the board of directors. The affairs of the society are managed by the said board of directors consisting of 15 members, out of which five seats are reserved for women and one seat is reserved for scheduled cast/scheduled tribes. The Chief Executive is the ex-officio member of the board of directors. All the directors except the Chief Executive and the co-opted directors shall be elected by the members in the General Body Meeting. The period of office for the elected directors is five years from the date of election.

Currently there are two kinds of insurance models in existence

1. Partner-agent model
2. Mutual model

Under the partner-agent model, ESCCO offers personal accident policies to all group members, which are in turn supported by United India Insurance Company and Future Generali Insurance Company (under a group personal accident policy). Under this policy, policyholders get an accidental cover of INR 100,000 and normal death cover of INR 50,000 (USD 769). In addition to this, funeral expenses of INR 1,000 (USD 15) are provided immediately. The premiums charged are INR 200 and 400 respectively (USD 3.1 and USD 6.2), based on the duration of the loan taken (one year or two year). In the last year of the policy, it was found that almost 35 claims got rejected due to policy conditions, such as:

- Death due to falling in water.
- Death while crossing the railway line.

Hence, to compensate a family in this instance, the mutual model is used. ESCCO maintain a member welfare fund which is used for supporting such declined claims, and also for skills development or conducting medical camps. A major portion of this fund (approximately 60%) is used for paying the claims alone.

Table 6:

Type of insurance *	7.2 Risk cover	7.3 Premium amount	7.4 Geographical outreach (name of states or districts covered)	7.5 Outreach (number of lives covered)
Credit life	Personal accident coverage of INR 100,000 (USD 1,540) Normal death coverage of INR 50,000 (USD 769) and funeral expense coverage of INR 1,000 (USD 15)	INR 200 (USD 3.1) for one year loan duration and INR 400 (USD 6.2) for the two year loan duration	Kerala, Tamil nadu, Chattisgarh, Maharashtra and Madhya Pradesh	427,018

Business case of the model (source of funding/financial sustainability)

The model is currently bundled with cooperative members' loan product.

Major reasons for success of the model

The model is currently bundled with cooperative members' loan product.

Major issues and challenges

Currently ESCCO does not offer any asset insurance, whereas because of the risk of natural catastrophic events and ever changing climatic conditions, members are interested in this kind of insurance. The complexity involved in servicing an asset insurance policy is preventing ESCCO from entering this area. In addition, scaling up of capacity in terms of reinsurance support as well as regulatory reorganization are some of the major hurdles for the ESCCO founders in starting a fully-fledged mutual insurance model. If there is clarity on these fronts, they would like to venture into health mutual insurance in first phase, and other products in the future.

Replication and expansion plans

ESCCO have suggested the formation of a national level forum of all like-minded people, to understand best practices in mutual insurance and learn from other's experiences.

ESCCO is interested in starting a fully-fledged mutual model for a health insurance product. There is huge demand for health insurance products from the SHGs.

They are looking for support on the following fronts to start a fully-fledged mutual model in the near future;

- Technical support
- Reinsurance support
- IT support
- Regulatory reorganization will help for expansion
- Opportunity to learn best models outside

Case study 7

Overview of the Calcutta Hospital & Nursing Home Benefits Association Limited (CHNHBA)

Insurance model: Mutual insurance company, recognized by the Insurance Act post-independence

Geographical reach: Kolkata

Primary beneficiaries: General public

Product(s): Health insurance

Mutual/community-based features unique to the model: Perhaps the only mutual scheme in India allowed to exist legally until 2015

Organization's willingness to scale or start mutual insurance: After the 2015 amendment to the Insurance Act, its existence is unclear

Number of current members/beneficiaries: 22,000

A study of the CHNHB Association was considered important for the ICMIF country study as this was the only mutual which was given a special status as exempt from the General Insurance Business (Nationalisation) Act, 1972.

However, as the efforts to study the CHNHB Association closely did not come to fruition, the authors have compiled a few excerpts on the Association so that the country study is not found incomplete. The two sources of the information are (i) ***"Private Health Insurance in India: Promise and Reality"***[37] by BearingPoint, Inc. for USAID in February 2008 and (ii) the General Insurance Business (Nationalisation) Act, 1972, which were found the most reliable sources.

i. Excerpts from "Private Health Insurance in India: Promise and Reality" by[38] BearingPoint, Inc. for USAID in February 2008.

"The Insurance Act of 1999 required that all companies selling insurance must be for-profit and, as a result, except for exempted organizations, there are no non-for-profit companies that are licensed, with one exception: in the private sector, the CHNHBA Association (formerly known as The Calcutta Hospital & Nursing Home Benefits Association Limited), which has been operating since 1948, ***was grandfathered into the Act and allowed to keep operating as a mutual insurance company*** *(emphasis added)."*

Overview

"The CHNHB is an excellent example of how a well-managed health insurance plan can succeed due to a long history of a strong board with a vested interest in making its coverage and rates meet the needs of its members. Since it is only in the business of insurance it is focused on making its plan work. Through its management and philosophy it has been able to provide more liberal benefits than normal and through its virtual elimination of age rating it has overcome one of the major deficiencies of the Indian Health Insurance industry. By offering affordable coverage at a single price to its members as they move through life, members are able to maintain access to benefits at the point when they are most likely to need them. This compares to other private insurers who heavily weight premiums by using age bands and often medically underwrite after a certain age."

Background and description of the CHNHBA

"The CHNHB Association (formerly known as The Calcutta Hospital & Nursing Home Benefits Association Limited) is a pioneer in the health insurance business in India. ***CHNHB is a public limited company registered with the Insurance Regulatory and Development Authority. Established in 1948, the Company has offered health insurance for fifty-eight years. The CHNHB was exempted from nationalization under the General***

[37] This analysis is based upon interviews with the management and directors of the plan, and on their official reports. It also draws on the knowledge of the interviewer. (Comment by Bearing Point authors)

[38] This analysis is based upon interviews with the management and directors of the plan, and on their official reports. It also draws on the

Insurance Business (Nationalisation) Act of 1972, because it was considered to be a non-profit distributing mutual benefits association. It was exempted from the provisions of the Insurance Act, 1938, which in practice allowed only stock companies to participate in the business of insurance, and as a result is the only licensed mutual health insurance company in the Indian insurance sector. *The company is run by an active board of directors whose members (except for the Medical Referee who is an eminent surgeon) have years of experience at director's level in corporate bodies and professional firms. A Chartered Accountant is the Chief Executive/Secretary of CHNHB and operates the affairs of the Company under the overall supervision and guidance of the board. There are three other executives, among them a Chartered Accountant who is also the Finance Manager/ Assistant Secretary. The Company has 15 employees.* ***The Association is relatively small and stable with approximately 22,000+ members and most of its business is centred in Kolkata (Calcutta) and the State of West Bengal. It does however, have members in several other states throughout the country. Most of its membership comes from corporate accounts although it does enrol individual members*** *(emphasis added)."*

CHNHB - financial performance[39]

"The company is very stable financially and the volume of its claims and average cost per claim have remained stable for the past two years in spite of medical cost and utilization increases in the healthcare industry. Its board actively oversees the business and has accumulated significant reserves (although as a mutual company it is not required to maintain a set amount). The investment income from this reserve is used to subsidize the premium prices and to keep the plan profitable. The board, in effect the owner of the Plan, decides when to increase the premiums it charges itself."

As per figures published in IRDAI Journal[40] CHNHB had INR 11.4 billion (USD 175 million) of investments as on 31 March 2004.

CHNHBA health insurance policies

"CHNHBA health insurance policies are liberal but typical for the industry. They provide coverage against hospitalization expenses in a registered hospital or nursing home in India. The policy also covers domiciliary hospitalization expenses subject to meeting certain limits. CHNHBA reimburses directly to the policyholder and no cashless facility is available. At present, the claim settlement period is around 9 working days. There are no unusual efforts to contain costs beyond the efforts of management to make sure they are paying only covered care is reimbursed."

Benefits

"The Association offers several benefits that would be considered very liberal for the Indian market.

They include:

- ***Maternity:*** *Benefits are extended to the policyholders under the normal provisions of the schedule of benefits. CHNHBA's maternity benefit has a waiting period of nine months.*
- ***Coverage of children:*** *A child can be covered from date of birth as long as a relatively small payment is made at least two months in advance of birth. However, the post-natal benefit for the first two months of expenses is capped. Otherwise, coverage begins after two months.*
- ***Dental treatment:*** *Coverage is quite flexible in paying claims for dental treatment within specified limits.*
- ***Ambulance coverage:*** *Charges for hiring an ambulance are paid up to INR 300 (USD 4.6)/for each trip subject to a maximum of INR 1,200 (USD 18)/per hospitalization.*
- ***Miscellaneous:*** *Coverage is provided for procedures such as circumcision under normal circumstances and voluntary termination of pregnancy in the first year of membership, contrary to the industry practice.*

[39] Financial performance information is based on 58th Report and Accounts of CHNHB Association and analysis.
[40] IRDAI Journal December 2004.

Membership

Coverage under the policy is liberal for the industry and is available to members' spouses and dependent children. Membership commences with a waiting period of two months before coverage begins and is extended for life without any medical examination. While there is an age restriction of 60 years for entry into the policy, the policy can continue above 60 years if renewed without break. In case of death of a policyholder, membership is offered to the dependents. Separate membership is offered to dependents included in the policy on attainment of 18 years of age.

Premiums

Prices charged to all members for insurance are set irrespective of the group to which they belong. As long as they are members there are only two different rates, one for individuals up to 18 years of age and another for all above 18 years which can be extended to the rest of their life with no age cut-off points."

ANNEXURE B: IAIS DEFINITIONS OF MCCOS

The "Issues paper on the regulation and supervision of Mutuals, Cooperatives and other Community-based organizations in increasing access to Insurance markets" (October 2010) of the IAIS states the broad contours of the key defining characteristics of MCCOs.

The paper states that the "key defining characteristics of MCCOs are as follows.

Member ownership: At least some of the beneficiaries of the services provided by the organization are, by virtue of their membership, also owners of the organization or have powers similar to those held by owners in shareholder organizations.

Democracy: By exercising ownership-type powers, the members form the general assembly of the organization and, through this forum, can exercise democratic rights on ultimate decision making such as the election of directors to the governing board.

Solidarity: The extent members are seeking a beneficial outcome where this beneficial outcome is reliant on the membership of the group. This concept is particularly relevant to the issue of capital (refer to the discussion below under "Insurance Core Principles, ICP, 23: Capital Adequacy and Solvency").

Created to serve a defined group and purpose: The organization is established and members become affiliated with the organization, through a common goal, purpose, or characteristic!

Entitlement to profit: The profit (or surplus) or loss (deficit) accruing to the members. In the case of losses, there can be a variety of treatments depending on the regulation in each jurisdiction."

The IAIS recognizes that MCCOs "may include organizations and institutions that are not registered under any specific law or regulation; recognized under a specific law even if not distinguished for insurance purposes; recognized under the insurance law itself."

MCCOs are described as: "Mutuals, Mutual Benefit Organizations, Cooperatives, Friendly Societies, Burial Societies, Fraternal Societies, Community-based organizations, Risk pooling organizations, Self-insuring schemes."

The IAIS recognizes that the scope of activities of MCCOs may vary widely.

"Some MCCOs can be risk carriers acting as insurers and their commitments towards policyholders are substantially identical to those of "conventional" insurers. Other MCCOs may adopt more specific restricted activities. In some markets, conventional insurers have responded well to the challenges of providing direct access to insurance services. In others, one solution to the challenges has been to recognize the roles MCCOs can play. These roles can form the basis for the regulatory approach recognizing the characteristics that may exist in varying degrees.

There are a number of ways MCCOs can provide insurance services to their members in the following ways. As distributors; MCCOs can act as a channel to clients when they are already acting to bring together client groups and may, in some cases, represent a cost effective and efficient way in which products can be explained and offered to clients. The key challenge of enrollment of members can be facilitated. In some cases, this distribution is formalized as an agent of an insurer.

As collectors of premiums; where the infrastructure and normal functioning of the MCCO can be a way to consolidate payment of premiums that can then be aggregated and transferred to the insurer, thus providing cost savings.

As a part of the claims assessment process; just as microcredit institutions have found it useful to make use of the community organization as a considerable aid in managing loan payments and reduce the risk of delinquency, insurers can find that moving as much of the claims assessment processes as close as possible to the customer can have advantages in reducing costs and ensuring timely claim payment. As the policyholders of a group insurance product covering the members of the association; MCCOs can provide a critical element of the insurance delivery process to reduce cost by providing a natural aggregation of clients into groups. Group based insurances tend to be a lower cost option compared to individually-issued insurance delivery. Similar to other group insurance arrangements, the record keeping associated with knowing the list of insured risks etc may be an administrative benefit provided by the MCCO. The MCCO may enhance its infrastructure in this area through its relationships with other institutions.

As a part of the process of understanding and relating to the customers; MCCOs can sometimes have a more intimate relationship with members and amongst members who often come from the same community. Besides managing the risk of fraudulent claims, this provides them with the opportunity to better understand the needs of members. Knowledge of the characteristics of the group also makes pricing easier and removes many of the information asymmetries facing other insurers. MCCOs can act as a voice of their membership when insurers are looking to design effective products and services.

As a part of the process of educating customers on the operation of the insurance services, and financial literacy generally.

As providers of ancillary or complementary services: These could include education on health, provision of other services to compliment the insurance service, or other parts of an overall package for the client. Common examples, but not the only ones, would be the provision of other financial services provided by cooperative microcredit institutions or the provision of health delivery.

As a vehicle to reinforce trust in the products: One of the main reasons for the success of MCCOs in low-income markets is their ability to reinforce trust in the insurance product. This is dependent on the effectiveness of the characteristics noted in paragraph 12. It is sometimes the case that more formal institutions are considered by the informal and lowest income segments as not being “for them”. This is also a reason why member-owned structures often evolve spontaneously in lower-income communities.

As a means of reducing costs and making insurance more affordable; in particular, for those with limited resources and for small premium and claim amounts, every effort made to find cost effective ways to deliver the services will be critical. Even when services are available, they may be too expensive for some segments. An MCCO acting as an aggregator of clients can support the product delivery whether or not the product is formally a group insurance contract or individual contracts leading to cost savings making the products affordable; and although in some business models, the MCCO relies on a conventional insurer to be the risk carrier, in others the MCCO may carry some or all of the insurance related risk directly and has demonstrated its ability to do so effectively. There is some evidence that mutuality and surplus retention can help customers with low insurance literacy to accept insurance even when they purchase insurance and no claim arises. In an MCCO structure, the value may be more readily perceived by clients when there is no claim on an insurance product providing risk cover only (emphasis added).”

ANNEXURE C: SELECT PROVISIONS OF INSURANCE (AMENDMENT) ACT 2015

*"**2C.** (1) Save as hereinafter provided, no person shall, after the commencement of the Insurance (Amendment) Act, 1950 (47 of 1950), begin to carry on any class of insurance business in India and no insurer carrying on any class of insurance business in India shall after the expiry of one year from such commencement, continue to carry on any such business unless he is:*

(a) a public company, or

*(b) a society registered under the "the Companies Act, 2013", or under any other law for the time being in force in any State relating to cooperative societies, or **(replaced vide new Act)***

(c) a body corporate, incorporated under the law of any country outside India, not being of the nature of a private company:

***provided** that the Central Government may, by notification in the official Gazette, exempt from the operation of this section to such extent for such period and subject to such conditions as it may specify, any person or insurer for the purpose of carrying on the business of granting superannuation allowances and annuities of the nature specified in sub-clause (c) of clause (11) of Section 2 or for the purpose of carrying on any general insurance business;*

***provided further** that in the case of an insurer carrying on any general insurance business, no such notification shall be issued having effect for more than three years at any one time;*

***provided also** that no insurer other than an Indian insurance company shall begin to carry on any class of insurance business in India under this Act on or after the commencement of the Insurance Regulatory and Development Authority Act, 1999.*

(2) Every notification issued under subsection (1) shall be laid before Parliament as soon as it may be, after it is issued.

(3) Notwithstanding anything contained in sub-section (1), an insurance cooperative society may carry on any class of insurance business in India under this Act on or after the commencement of the Insurance (Amendment) Act, 2002."

The General Insurance Business (Nationalization) Act, 1972 (GIBNA)

The General Insurance Business (Nationalization) Act, 1972 (GIBNA) as amended in 2002, had provided that all the shares in the capital of every Indian insurance company shall, by virtue of this Act, stand transferred to and vested in the Central Government and the formation of General Insurance Corporation of India. Some specific exemptions were provided under the GIBNA, which under Section 36 stated the following.

"(1) Nothing contained in this Act shall apply in relation to –

(a) any general insurance business carried on by a State Government, to the extent to which such insurance relates to properties belonging to it or undertakings owned wholly or mainly by the State Government; or to properties belonging to semi-government bodies, or any board or body corporate established by the State Government under any statue or any industrial or commercial undertaking in which the State Government has substantial financial interest, whether as shareholder, lender or guarantor;

(b) any general insurance business not falling within clause (a) which has been carried on by a State Government before the commencement of this Act, to the extent to which it is necessary to allow such business to run off:

provided that nothing contained in this clause shall be deemed to authorize the State Government to issue any new policies or renew any existing policies;

(c) any insurer whose business is being voluntarily wound up or is being wound up by a court;

(d) the insurance business carried on by the Calcutta Hospital and Nursing Home Benefits Association Limited; (emphasis added)

(e) the insurance business carried on by the Export Credit and Guarantee Corporation Limited and the Deposit Insurance Corporation established under section 3 of the Deposit Insurance Corporation Act, 1961 (47 of 1961)

(f) any scheme in existence immediately before the 14th day of May, 1971 or any scheme framed after the said day with the approval of the Central Government for the insurance of crops or of cattle or of flood risks or of war or emergency risks.

(2) If the Central Government is satisfied that an insurer, whether established before or after the appointed day, carries on only such general insurance business as is not carried on ordinarily by insurers, it may, by notification, direct that nothing contained in this Act shall apply to such insurer (emphasis added)."

ANNEXURE C.1

The legal and regulatory position of mutuals and cooperatives in India have been examined in various studies, excerpts are given below.

G. Section 94A of the Insurance Act 1938

Section 94A of the Insurance Act 1938 inserted by the same Insurance (Amendment) Act 2002 reads as follows:

"94A. Insurance co-operative society to be an insurer:

(1) Every insurance co-operative society shall be deemed to be an insurer for the purposes of this Act.
(2) Save as otherwise provided in this Act, all the provisions applicable to as insurer being an Indian insurance company shall, so far as may be, apply to an insurance co-operative society;

provided that the Authority may, by notifications, direct that any of the provisions of this Act,

a. Shall not apply to any insurance co-operative society; or
b. Shall apply to any insurance co-operative society only with such exceptions, modifications and adaptations as may be specified in the notification.

(3) A copy of every notification proposed to be issued under sub-section (2) shall be laid in draft before each House of Parliament, while it is in session, for a total period of thirty days which may be comprised in one session or in two or more successive sessions, and if, before the expiry of the session immediately following the session or the successive sessions aforesaid, both Houses agree in disapproving the issue of the notification or both Houses agree in making any modification in the notification, the notification shall not be issued, or, as the case may be, shall be issued only in such modified form as may be agreed upon by both the Houses."

Sub section (1) of Section 94A clearly states that every insurance cooperative society shall be deemed to be an insurer for the purposes of this Act. The first part of sub section (2) provides that all provisions of the Act applicable to an Indian insurance company shall also apply mutatis mutandis to an insurance cooperative society, unless specifically exempted under any other provision of the Act.

The proviso to sub section 2 of Section 94A empowers the IRDAI to completely exempt an insurance cooperative society from any of the provisions of the Insurance Act 1938, or relax or modify the application of specified provisions of the Act. It also lays down the procedure for granting such exemptions or exceptions to an insurance cooperative society. The legislature therefore has clearly envisaged the need to make special exceptions for cooperatives and has empowered the insurance regulator in this regard.

H. The Consultative Group to Assist the Poor (CGAP) Working Group study on Yashaswini Trust

A study[41] by the CGAP Working Group on microinsurance points out that in addition to the provisions in the Insurance Act, *"Mutuals and Cooperatives are also regulated under state Acts; the Insurance (Amendment) Act 2002 refers to certain state responsibilities in this respect. The requirements for insurers in the Insurance (Amendment) Act 2002 are focused inter alia on registration, reporting, auditing, excess capital to absorb shocks, assets allocation and valuation, contractual issues, managerial qualifying conditions and agents. However, these requirements differ according to the legal entity operating insurance business.*

[41] CGAP Working Group on Microinsurance - Good and Bad Practices. Case Study No 20 by Ralf Radermacher, Natasha Wig, Olga van Putten-Rademaker, Verena Müller and David Dror, 2005
Source: http://www.ilo.org/wcmsp5/groups/public/@ed_emp/documents/publication/wcms_122476.pdf

The capital requirement consists of three components: (a) paid up capital before registration can be applied for (which requires a registration fee that needs renewal on a regularly basis); (b) deposited capital; and (c) working capital (or the "solvency margin", defined as the surplus of assets over liabilities).

The requirements for provident societies, mutuals and cooperative societies mentioned in the Insurance (Amendment) Act 2002 are different with respect to capital requirements including registration (as shown in Table 1.2); there are also key differences in reporting and auditing.

Table 7: Requirements for mutual/cooperative insurers

	Mutual companies	Cooperative life insurance societies
Paid up capital	INR. 15,000 (*) USD 225 (approx.)	INR 15,000 USD 225 (approx)
Registration fee	n.a.	n.a.
Deposit capital	INR 200,000 (**) USD 3,000 (approx.)	INR 200,000 (**) USD 3,000 (approx.)
* Capital requirements are not further specified in the Act; may be paid up capital, or surplus capital.		
** Deposits explicitly mentioned for life insurance; not general insurance.		
n.a. = not available in Insurance (Amendment) Act 2002		

Provident societies are limited in the provision of benefits in type and amount. The cooperatives mentioned provide life insurance and the mutuals are not explicitly restricted in their activities. They all are required to be non-profit organizations."

I. IRDAI concept paper

A concept paper on the *Need for Developing Microinsurance* in India (18 August 2004) to increase coverage for the rural population was issued by the IRDAI. In November 2005, the IRDAI issued microinsurance regulations for the partner-agent model. It is significant to note that models other than the partner-agent are not part of the regulation.

J. MCRIL study

A study[42] by the Micro-Credit Ratings International Limited (MCRIL) points out that under the current regulations, *"There is no provision for establishing a mutual insurance company in India at present."*

The MCRIL recommends that the provision of microinsurance by mutual organizations and cooperatives should be addressed by the regulation. *"Insurance regulation in India does not explicitly recognize any special needs for the provision of microinsurance by mutual organizations (including cooperatives). Yet . . . there is a significant amount of such activity taking place though it caters to a minuscule proportion of the potential microinsurance market. Some of the largest microinsurance programs in India started as cooperatives. VimoSEWA is one such example. It started by providing insurance cover to its members by pooling risks and has now shifted the risk burden to two life and three non-life insurance companies. Similarly, state governments are not averse to the provision of microinsurance by mutuals and cooperatives."*

"The Yeshasvini Trust in Karnataka, which operates on the cooperative model, is probably the largest microinsurance program in the country with coverage of 2.3 million policyholders."

[42] Microinsurance regulation in the Indian financial landscape by Micro-Credit Ratings International Limited MCRIL, 2008
Source: http://www.m-cril.com/BackEnd/ModulesFiles/Publication/Micro_Insurance_Regulation_In_The_Indian_Financial_Landscape.pdf

"In recent years, given the lack of a facilitative framework for this activity a number of mutual insurers (like VimoSEWA) have entered into collaborations with large insurance companies and become aggregators instead. While this collaboration with conventional insurers could be a benefit from a prudential perspective, another view is that this means a loss of knowledge and experience of small-scale under-writing, on the one hand, and the loss of potential outreach, on the other. Potential outreach is lost through the mutual organizations having to conform to prudential norms as well as market conduct regulation and pricing structures suited more to the operations of large insurers than to the needs of mutual organizations. The creation of risk pooling mechanisms for mutual insurers and design of appropriate governance and market conduct rules for mutual insurers could go a long way in increasing outreach. The import of experience in this field from other countries could also be of benefit."

The MCRIL also recommends that providers of microinsurance need not be subjected to the same regulatory burden as other insurers and argues that since *"the overall volume of risk carried by microinsurers would be a lot lower, the creation of a separate category of microinsurers would almost automatically indicate a lower minimum capital requirement. For such microinsurers, the regulator would need to ensure that appropriate governance norms were applied to ensure that clients were provided services of a reasonable quality and did not become victims of fraud. If caution prevails, this category could be limited to mutual benefit/ cooperative organizations to begin with."* The enabling of appropriate market conduct regulation for this purpose and lowering insurance costs were also touched upon by the study.

The MCRIL study points out that *"with limited enforcement capacity, the Indian regulator has chosen to focus only on the large insurance companies licensed by it, on areas of higher risk and that this approach leaves out mutual organizations that are providing (or are able to provide) insurance cover to clients. One reason for not enabling more insurers to operate in the microinsurance market is obviously the concern of the regulator that its supervisory capacity is limited and increased numbers of insurers would stretch that capacity. This can be best addressed by introducing a range of levels of supervision, whereby those insurers judged to have lower risk bearing capacity and those carrying higher levels of risk (in terms of types of cover provided or areas serviced) are subject to greater supervision than those in other fields."*

K. CGAP Working Group study on Karuna Trust

Another study[43] by CGAP on Karuna Trust, Karnataka points out the role of the State in insurance. It states that the Constitution of India assigns the responsibility for various issues to the Union (Central Government), to the individual states, or to both; and that insurance is a federal task. The Constitution assigns *"incorporation, regulation and winding up of trading corporations, including banking, insurance and financial corporations, but not including cooperative societies" to the union's responsibilities. The state is involved in the "incorporation, regulation and winding up of corporations (other than those specified in the Union list), and [...] other societies and associations; cooperative societies."*

"Both, Union and State(s), have concurrent competences regarding "bankruptcy and insolvency" for all entities not further specified, including trade unions, social security and social insurance, as well as charities and charitable institutions. The insurance industry was nationalized in India, life insurance in 1956 and general insurance in 1973. In 1999, the insurance market reopened for (limited) competition with the entry of private companies, following the establishment of the Insurance Regulatory and Development Authority (IRDA) by an Act of Parliament. Established by the federal government, the IRDA has extensive duties, powers and competencies to regulate promote and ensure growth of the insurance and re-insurance industry, including licensing, contractual conditions, standards for qualifications of management and intermediaries, operational affairs and supervision. IRDA also has the authority to launch investigations and conduct inspections

[43] CGAP Working Group on Microinsurance - Good and Bad Practices. Case Study No 20 Ralf Radermacher, Olga van Putten-Rademaker, Verena Müller, Natasha Wig, David Dror, 2005.
Source: https://www.microinsuranceacademy.org/wp-content/files_mf/13849630272005_KarunaTrustKarnataka.pdf

of licensed insurance companies at any time it deems fit, and can cancel the registration or close down an insurance firm. The Central Government is empowered to bypass the IRDA in policy related issues (Section 18, IRDA Act 1999) and may act and supersede IRDA under various conditions, e.g., in the "public interest" (Section 19 IRDA Act 1999). An "insurance company" in India means any company formed and registered under the Companies Act 1956 whose sole purpose is to carry on insurance or re-insurance business. . . . .

A cooperative society registered under the Co-operative Societies Act 1912 can operate life insurance or general insurance under State regulation (not federal). Cooperative societies, mutual insurance companies and provident societies are allowed to provide insurance as non-profit organizations. They are explicitly mentioned in the Insurance (Amendment) Act 2002, which integrated the IRDA Act (1999) with the Insurance Act 1938.

There is some opaqueness in the Insurance Amendment Act 2002 regarding cooperative societies. Section 2, subsection 8A, stipulates that on matters of capital requirements and foreign ownership, cooperatives registered on or after the commencement of the Insurance (Amendment) Act 2002 must comply with the conditions applying to insurance companies under the Companies Act. However, Section 96 of this Act explicitly states that the (huge) paid-up capital requirements for registration and capital deposits do not apply to mutual insurance companies and cooperative life insurance societies. . . . This reporting of cooperatives and mutuals is to State Registrar of Companies."

L. MicroSave Focus Note

A focus note published by MicroSave[44] states that in 2005, the ILO had identified 83 microinsurance products (filed by 19 insurance companies) in India, of which, 42 were life and 41 were general (mostly health) insurance products. Some MFIs, cooperatives, health mutuals and health service providers also provided life, health and other general insurance products either independently or through some partnership with insurance companies. The ILO reported 60 such products providing insurance services, of which nine were sold without any insurance company partnership.

The IRDAI appeared to exercise "benign neglect" towards such programs, possibly since these are negligible in outreach, and are reaching out to the market segments beyond the financial mainstream where insurers do not appear keen to get into.

M. RBI Report

The Report[45] of the Reserve Bank of India's (RBI) *Committee on Comprehensive Financial Services for Small Businesses and Low-Income Households* while discussing design statements and design principles, proposes four broad design principles, viz. systemic stability, transparency, neutrality, and responsibility. It points out that for *"an emerging market like India, financial inclusion and depth are no doubt important public policy goals".*

The report underscores the vision for *"Universal Access to a Range of Insurance and Risk Management Products at Reasonable Charges"*. It states the vision that by *"January 1, 2016, each low-income household and small business would have "convenient" access to providers that have the ability to offer them "suitable" insurance and risk management products which, at a minimum allow them to manage risks related to: (a) commodity price movements; (b) longevity, disability, and death of human beings; (c) death of livestock; (d) rainfall; and (e) damage to property, and pay "reasonable" charges for their service."*

[44] Microinsurance Product Types in India: Focus Note 86 MicroSave India, 2012
Source: http://www.microsave.net/files/pdf/IFN_86_Microinsurance_Products_Types_in_India.pdf
[45] Report of RBI's Committee on Comprehensive Financial Services for Small Businesses and Low-Income Households Vision Statements and Design Principles 2014
Source: http://rbi.org.in/scripts/PublicationReportDetails.aspx?UrlPage=&ID=733

While discussing the concerns of providing universal access to insurance, the report states that a *"comparison with global averages of level of protection, measured as the ratio of the sum assured to gross domestic product (GDP) reveals that while this ratio is 58% for India, it is much higher in other countries like the USA (191%), Germany (105%), France (97%), South Korea (152%) and Japan (321%)."*

Table 8: Insurance penetration in various countries

Parameters	Year	Country	Life	Non-life	Total
Insurance penetration (aggregate premiums to GDP)	2011	Australia	3.0%	3.0%	6.0%
		UK	8.7%	3.1%	11.8%
		USA	3.6%	4.5%	8.1%
		Brazil	1.7%	1.5%	3.2%
		Russia	0.1%	2.3%	2.4%
		Bangladesh	0.7%	0.2%	0.9%
		India	3.4%	0.2%	0.9%

The report mentions that though India generally compared fairly with other countries in terms of level of protection and insurance penetration, the reach and effectiveness in respect of focus areas like life insurance and specifically the extent of term life insurance penetration was not clear.

In this context and in view of global benchmarks, the report emphasizes that the currently available data does not help in painting *"a picture of the depth of insurance penetration in terms of the sum assured measured as a per cent of GDP for rural and urban areas for each district"*. It states that *"from a field perspective, the average GDP for a Gram Panchayat in India is estimated to be about INR 120 million[46] and the total Human Capital requiring coverage for an average rural household is about INR 0.35 million[47]. Assuming that the average population of a Gram Panchayat is 3,000 (or 600 households), the Total Sum Assured required to cover the human capital of all earning members of the Gram Panchayat population is INR 210 million[48]. This implies that in order to cover the entire human capital of a Gram Panchayat, the Sum Assured to GDP ratio will be in the region of 175%."* The report goes ahead to set a tangible Goal – *"A Total Term Life Sum Assured to GDP Ratio of 30% by January 1, 2016, increasing by 12.5% every year until it reaches 80% by January 1, 2020, in every District of the country."* It also envisions *"convenient access to insurance and risk management products would be provided by a combination of payment access points and credit access points."*

The RBI report observes that *"One crucial tool to ensure stability is capital, in adequate quantum for a given type of risk. The offering of financial services entails the assumption of three broad types of risks: (a) market (including liquidity) risk; (b) credit risk; and (c) operational (including settlement, legal and reputational) risk. Each entity that aspires to participate in this process, no matter how large or small its role, needs to clearly identify the specific risks to which it is exposed and to have an adequate amount of capital to absorb that risk. While it is generally accepted that institutions that are permitted to warehouse insurance risks or hold deposits on their balance sheets, need to have a level of capital that reflects their underlying risk profile, it is often assumed that agents of financial institutions do not need to hold any capital at all.*

It is pertinent that in this context the report points out as follows: *"The concept of mutuals such as cooperatives and self-help groups are a notable exception to this principle though it is a subject of intense debate if such mutuals are indeed able to offer their constituents a degree of protection that is comparable to that offered by more traditional structured financial institutions such as commercial banks which need to adhere to much stricter capital adequacy rules.*

[46] USD 1.85 million
[47] USD 5,380
[48] USD 3.23 million

N. Munich Re Foundation

At Munich Re Foundation's microinsurance conference[49] in 2007 in Mumbai, India's lead in recognizing microinsurance as a distinct activity with a separate set of regulations was discussed. Speaking at the conference, Michel Flamie, Chair, IAIS Executive Committee, emphasized the need for mutuals or cooperative insurers to serve the low-income market, saying, *"It may be necessary to recognize different types of insurance providers for different population segments. For example, in many emerging markets, mutual or cooperative insurers seem particularly well positioned to serve the low-income market."* Flamie observed that an enabling policy environment was *"essential for the development of microinsurance institutions"* and added that, *"implementing financial regulation for microinsurance operators entails the challenge to formulate a framework that not only takes into account the unique characteristics peculiar to the microinsurance business, but also avoids putting conventional insurance companies at a comparative disadvantage."*

O. Bearing Point study for the United States Department for International Development (USAID)

A study[50] by Bearing Point Inc. states that *"The Insurance Act of 1999 required that all companies selling insurance must be for-profit and, as a result, except for exempted organizations, there are no non-for-profit companies that are licensed, with one exception: in the private sector, the CHNHBA Association (formerly known as The Calcutta Hospital & Nursing Home Benefits Association Limited), which has been operating since 1948, was grandfathered into the Act and allowed to keep operating as a mutual insurance company."*

"The CHNHB was exempted from nationalization under the General Insurance Business (Nationalization) Act of 1972, because it was considered to be a non-profit distributing mutual benefits association. It was exempted from the provisions of the Insurance Act, 1938, which in practice allowed only stock companies to participate in the business of insurance, and as a result is the only licensed mutual health insurance company in the Indian insurance sector."

[49] Microinsurance regulations here get global pat The Economic Times, 15 November 2017
Source: http://articles.economictimes.indiatimes.com/2007-11-15/news/27685382_1_microinsurance-insurance-supervisors-insurance-companies

[50] Private Health Insurance in India: Promise and Reality BearingPoint, Inc, 2008

ANNEXURE D: GLOSSARY

List of definitions

Co operative Life Insurance Society	An insurer being a society registered under the Co operative Societies Act, 1912 or under an Act of a State Legislature governing the registration of cooperative societies which carries on the business of life insurance and which has no share capital on which dividend or bonus is payable and of which by its constitution only original members on whose application the society is registered and all policyholders are members.
General insurance business	Fire, marine or miscellaneous insurance business, whether carried on singly or in combination with one or more.
Insurance cooperative society	Any insurer being a cooperative society which is registered on or after the commencement of the Insurance (Amendment) Act, 2002, as a cooperative society under the Co-operative Societies Act, 1912 (two of 1912) or under any other law for the time being in force in any State relating to Co-operative Societies or under the Multi-State Co-operative Societies Act, 1984 (51 or 1984) having a minimum paid-up capital, of INR 1 billion (USD 15.4 million) ; in case of life insurance business, general insurance business and health insurance business, and whose sole purpose is to carry on life insurance business or general insurance business or health insurance business in India.
Mutual microinsurance	Refers to pro-active efforts at providing insurance services to low-income or marginalized groups in a manner where they participate in the design, development, management and governance of such product, services or institutions.
Mutuals, Cooperatives and other Community Based Organizations (MCCOs)	Mutuals, mutual benefit organizations, cooperatives, friendly societies, burial societies, fraternal societies, community-based organizations, risk pooling organizations, self-insuring schemes (IAIS) Or An autonomous association of persons united voluntarily to meet their common economic, social and cultural needs and aspirations through a jointly owned and democratically controlled enterprise (ICMIF) Or A mutual is a legal entity whose purpose is primarily to meet the needs of its members (legal or natural persons) according to the principles of solidarity and mutuality amongst them. The profits and surpluses of a mutual are not used to pay a return on investment, but to improve the services offered to members, and to finance and develop their activities for the benefit of members (EU).
Mutual insurance company	An insurer, being a company, incorporated under the Indian Companies Act, which has no share capital and of which by its constitution only and all policyholders are members.

LIST OF ABBREVIATIONS

A2II	Access to Insurance Initiative
AABY	Aam Aadmi Bima Yojana
AIC	Agriculture Insurance Company of India Limited
ARM	Alternative Risk Management
ASC	ICMIF Academic Steering Committee on Financial Inclusion
BPL	Below Poverty Line
CBO	Community-Based Organization
CDT	Claim Decision Tool
CGAP	The Consultative Group to Assist the Poor
CHNHBA	The Calcutta Hospital and Nursing Home Benefits Association Limited
CLM	Community Livestock Manager
CSR	Corporate Social Responsibility
DCCB	District Cooperative Bank
FGD	Focus Group Discussions
FY	Financial Year
GDP	Gross Domestic Product
GIBNA	General Insurance Business Nationalization Act
IAIS	International Association of Insurance Supervisors
ICMIF	International Cooperative and Mutual Insurance Federation
ICP	Insurance Core Principles
III	Insurance Institute of India
ILO	International Labour Organization
ILO MIF	International Labour Organization Microinsurance Innovation Facility
IRDA/IRDAI	Insurance Regulatory and Development Authority of India
IVRS	Interactive Voice Response System
LIC	Life Insurance Corporation of India
MCCO	Mutuals, Cooperatives and Other Community Based Organizations
MCRIL	MicroCredit Ratings International Limited
MFIs	Micro Finance Institutions
MIS	Management Information System
NAIS	National Agriculture Insurance Scheme
NGO	Non-Governmental Organization
PSC	Parliamentary Select Committee
PACS	Primary Agricultural Cooperative Society
PRA	Participatory Rapid Appraisals
RBI	Reserve Bank of India
RSO	Rural and Social Obligations
RSBY	Rashtriya Swasthya Beema Yojana
SEBI	Securities and Exchange Board of India
SERP	Society for Elimination of Rural Poverty
SAG	Self Help Affinity Group
SCB	State Cooperative Bank
SDGs	Sustainable Development Goals
SHG	Self Help Group
TO	Takaful Operators
UDSS	Uplift Development Solutions and Services
UN	United Nations
USAID	United States Department for International Development
USP	Unique Selling Point
VCF	Venture Capital Fund
VLE	Village Level Entrepreneurs

NOTES

The Insurance Institute of India (III), was established in the year 1955, for the purpose of promoting insurance education and training in India. III courses leading to Associate/ Fellow (AIII/FIII) certifications, specialized Diploma and training programs conducted by its College of Insurance are held in esteem both by the regulator and the industry in India and in many other countries. In its role as a leading education and training provider, III is closely associated with all the segments of the insurance industry which includes the Insurance Regulatory and Development Authority of India (IRDAI), both public and private sector insurance companies. III is Member of the Institute of Global Insurance Education (IGIE) and involved with global bodies like the International Insurance Society (IIS) and the Insurance Development Forum (IDF) in addition to several universities in India.

The International Cooperative and Mutual Insurance Federation (ICMIF) is a best practice organization committed to giving its members from around the world a competitive advantage. ICMIF helps to grow its mutual and cooperative insurance member organizations by sharing strategies and the latest market intelligence.

ICMIF

Denzell House, Dunham Road, Bowdon, Cheshire, WA14 4QE, UK

Tel: +44 161 929 5090 Fax: +44 161 929 5163;

Follow us on Twitter @icmif_micro
Watch our videos on Youtube - youtube.com/ICMIFmicroinsurance

Date published: July 2017

www.icmif555.org

---

icmif

International Cooperative and Mutual Insurance Federation