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ANNAPURNA PARIWAR COMMUNITY/MUTUAL HEALTH INSURANCE PROGRAM

A CASE STUDY IN MAHARASHTRA, INDIA

August 2017
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1. INTRODUCTION

Policymakers and regulators recognize the pivotal role that microfinance institutions (MFIs) play in expanding financial inclusion to the unreached and under-reached segments of the population in India. As per recent estimates, there are 223 MFIs in India (Sa-Dhan 2016). These institutions have a client base of 40 million members and total loan portfolio of Rs. 638.53 billion ($10 billion), putting the average loan per borrower in the range of Rs. 16,000 ($251) (Sa-Dhan 2016).[1] The non-performing assets of these institutions is less than one percent with median operating expenses of 10.2 percent. Many of these institutions have developed and implemented health insurance programs along with their micro credit programs using a "community/mutual" model or "partner-agent" model (see Annex A). These programs provide protection from catastrophic out-of-pocket (OOP) spending on health to members and their families. MFIs can be a good aggregator of clients, thereby reducing the administrative cost of managing a health insurance program, and have potential to reach 150 million people.

Annapurna Pariwar is a group of five development organizations in Maharashtra state that strive to empower poor women and their families in areas such as financial inclusion and health.[2] In 2003, its member organization for microcredit, Annapurna Mahila Cooperative Credit Society, developed and implemented a health insurance program – Annapurna Pariwar Vikas Samvardhan (APVS) – based on "community/mutual" concepts for the members of the credit society and their dependents. Unlike many community-based health insurance (CBHI) schemes that work with commercial insurance companies under a "partner-agent" arrangement, the Annapurna Mahila Cooperative Credit Society was one of the first institutions to integrate a health insurance program into its microcredit program according to the principles of cooperativeness and mutuality (see Annex B). Having operated APVS for more than a decade, Annapurna Pariwar's experience provides an interesting case for examining the relevance and appropriateness of such schemes in the Indian context and the contribution they can make to reduce OOP spending on health among people who are not covered by state or national health insurance schemes.

The objectives of this case study are to understand:

- the genesis and key features of Annapurna Pariwar's health insurance scheme,
- product design features,
- financial and operational performance of the scheme,
- risk management strategies,
- how the program addresses the outpatient health care needs of its members, and
- key challenges faced by the program.

[1] Exchange rate on 26 August 2017 is Rs. 63.88 = 1 US$.
[2] Annapurna Pariwar: http://www.annapurnapariwar.org/index.html. Accessed June 16, 2017.

This case study has been prepared from the following documents (a) notes from Skype call and field study interview with Annapurna management and collection of financial information from the Annapurna website, (b) draft notes by Dr. Somen Saha on his visit to Annapurna and (c) publications, reports, and presentations produced by Annapurna Pariwar. A detailed Key Informant Interview checklist was prepared and used while conducting the discussion and interviews for this case study; the checklist and list of people interviewed is available on request. Table 1 displays a snapshot of background information relevant to Annapurna Pariwar's operation and coverage in early 2017.

Table 1: Annapurna Pariwar Mutual Health Insurance Scheme: A Snapshot (March 31, 2017)

Category	Value
Annapurna Credit Society shareholders	100,235
Saving account holders	80,000
Number of borrowers and mutual insurance policies issued	60,940
Dependents covered	170,012
Total individuals covered (borrowers and dependents)	230,952
Family members covered (%)	99.07%
Family members per policy (target 4 members)	3.79
Premium single per annum (Rs)	150
Premium family per person per annum (Rs)	130
Maximum sum assured (Rs)	18,000
Claims to contribution to claim fund ratio	76%
Average claim (Rs)	4098
Hospitalization rate per 1,000 per year	15.02
Number of hospitals empaneled	137
Hospitalization using public providers (Mumbai)	50%
Operating self-sustainability (OSS) ratio	105%

Source: Annapurna Pariwar: http://www.annapurnapariwar.org/microinsurfin.html. Accessed August 29, 2017.

2. ANNAPURNA PARIWAR GROUP

As noted in the Introduction, Annapurna Pariwar[3] is a group of five organizations aiming to empower poor women by providing services in areas of credit, health, and education. The five organizations are (see also Annex B):

- Annapurna Mahila Multi State Cooperative Credit Society (Microcredit Lending)
- Annapurna Pariwar Vikas Samvardhan (Health Insurance)
- Vatsalyapurna Service Cooperative Society (Day Care Centers)
- Annapurna Mahila Mandal, Pune (Scholarship, Education and Training)
- Annapurna Mahila Mandal, Mumbai (Working Women's Hostel)

Annapurna Pariwar was founded in 1993 by Dr. Medha Samant, a banking professional who had left her regular job to work in slums of Pune. It now operates in more than 1,000 slums of Pune and Mumbai. The Annapurna credit society is registered with CRIF High Mark, a credit information bureau approved by the Reserve Bank of India. As per the Reserve Bank's guidelines, the credit society submits lending data to CRIF High Mark, which regularly monitors the data and confirms that there is no multiple lending to a single borrower. Micro loans are given for business and other needs of the poor. Loan sizes range from Rs. 7,000 to Rs. 500,000.

[3] In Indian mythology, Annapurna is a deity of food. "Annapurna Pariwar" means the Annapurna family.

3. HEALTH CHALLENGES IN COMMUNITY SETTINGS

India's public spending on health care is among the lowest in the world. As a result, public sector provision of health care is weak and underfunded and there is an over-reliance on private sector care, much of it unregulated in terms of price and quality. This lack of universal social health protection makes for high OOP spending on health care. Consequently, the poor frequently forgo seeking care when ill or delay seeking it – potentially making that illness more serious and care more expensive when they do visit a health provider. Many fall further into poverty or debt when seeking services (Mishra et al. 2008). Most poor families are vulnerable to catastrophic OOP health care spending, particularly if the earning members of the family get sick. Catastrophic OOP spending on hospitals in India pushes around 60 million people below India's poverty line every year (Government of India MoHFW 2017).

In 2008, the Government of India launched a national health insurance scheme for the poor, called Rashtriya Swasthya Bima Yojana (RSBY). Families living below the poverty line[4] are eligible to enroll in the scheme after paying a registration fee of Rs. 30 per family per annum. The family gets coverage for treatment costs up to Rs. 30,000 per annum in empaneled public and private hospitals (Swarup and Jain 2011). In addition, several state governments have initiated their own social health protection schemes to cover the poor against tertiary and hospitalization care expenses. The Rajiv Aarogyashri scheme in Andhra Pradesh, Vajpayee Aarogyashri scheme in Karnataka, Kalaignar in Tamil Nadu, and the Mukhyamantri Amrutum Yojana scheme in Gujarat are a few examples. These schemes cover, on a cashless basis,[5] higher-end tertiary care for people living below the poverty line (La Forgia and Nagpal 2012).

However, these social assistance schemes have limitations: as noted above, they cover only hospital treatment for families living below the poverty line. The population that is barely above the poverty line is not covered. For example, in the community that Annapurna serves, most members work in the informal sector and are near the poverty line but not quite poor enough to qualify for the government-supported health insurance schemes. They cannot afford commercial health insurance because of its high cost. APVS and other organizations offering CBHI fill this void and complement the government-sponsored health insurance schemes.

[4] The status of "below poverty line" as determined through survey is based on the degree of deprivation in respect of 13 parameters (with scores from 0 to 4) which include land holding, type of house, clothing, food security, sanitation, consumer durables, literacy status, labor force, means of livelihood, status of children, type of indebtedness, and reasons for migrations.

[5] In a cashless system, the patient does not pay out of pocket at the time of service. Instead, the insurer pays the provider on behalf of the patient for covered services according to the terms of agreement it has with the provider. This contrasts with the reimbursement basis, where the patient pays at the point of service and then seeks reimbursement.

4. FOUNDING OF THE ANNAPURNA PARIWAR HEALTH INSURANCE PROGRAM

Annapurna Pariwar became convinced it could start a health insurance program because it already had a well-functioning credit program that allowed it to know its members and the communities with which it worked. Fortnightly credit society meetings with members provided information on member background, needs, and living conditions. A high incidence of illness among members created risks for both the members and the credit society, because illness sometimes affected members' ability to work and thus to meet their loan repayment schedule. High OOP spending on health care placed a huge financial burden on members, often pushing them below the poverty line.

In the literature, MFIs are considered to be better equipped to implement micro-insurance than larger, more traditional, and more expensive entities like commercial insurance companies (Churchill and Matul 2012, DeLoach and Lamanna 2011, Chen et al. 2008, Dror et al. 2009). MFIs can use their organizational structure to enroll people efficiently, are known and trusted, and can perform financial transactions with or on behalf of members. Annapurna decided to design and implement a health insurance program to provide its members financial risk protection from the cost of hospitalization. Later, the program added other services such as arranging discounts on outpatient, diagnostic, and pharmacy services.

5. CHOICE OF HEALTH INSURANCE MODEL

APVS is registered as a Section 8 company (not-for-profit), a departure from the standard organizational approach of establishing entities like this one as a society or trust (see Annex C for a comparison of these three types of organizations). Just as in the case of a society or trust, a Section 8 company, APVS does not need to meet any minimum capital requirement, or have independent directors and a professionally qualified company secretary, helping it to minimize its costs and create governance structure consisting mostly of members. This enables Annapurna Pariwar to facilitate and maintain community ownership effectively.

Annapurna had to choose between the partner-agent model and mutual/cooperative insurance model (see Annex A for definitions of these models). The partner-agent model is used by commercial insurance companies in India to meet their mandated requirement of extending coverage to vulnerable groups of the population.[6] Many CBHI schemes in India have adopted this model. However, Annapurna found the partner-agent model did not fit well within its system of having control of its products, as under this model, the insurer and not the community decide the product design. Annapurna also predicted that the partner-agent model would require higher premiums and therefore be unaffordable and unattractive to its credit society members. Finally, Annapurna had long considered building members' health awareness and guiding them in their health seeking behavior as an integral part of the scheme. Annapurna felt that the partner-agent model would be less likely to help them in achieving these goals, compared to the 'mutual' model.

Mutuals are described as "voluntary groups of persons whose purpose is primarily to meet the needs of their members rather than achieve a return on investment" (Grijpstra et al. 2011). Mutuals operate according to the principles of solidarity among members, and their participation in the governance of the operations (European Commission 2003). An important characteristic of health mutuals is that the communities manage their risks without involving third parties in under-writing (Fischer 2006, Fonteneau 2006). A health mutual operates under a member-designed and member-managed health care financing model where, on becoming a member, households not only share their health financing risks and participate in scheme governance but also share prevention, guidance, and a multi-layered network of health care providers (Shailabh 2016). However, these features are not restricted to mutuals and mutuals may exist without such features. The main principle on which health mutuals are based and differ from other CBHI products is that the community owns the mutual and is the insurer. By owning the health mutual, member-users also own the decision-making power in such organizations where every person is counted as one vote (Churchill and Matul 2012).

[6] The Insurance Regulatory and Development Authority of India regulations obligate every insurer in India to provide insurance services to persons residing in rural areas, workers in the unorganized or informal sector or economically vulnerable, or backward classes of society. Health insurers must dedicate 2 percent of their business in their first financial year, 3 percent in second year, and 5 percent thereafter to serve these segments.

Annapurna was new to the concept of mutual-based health insurance. It received technical support and actuarial guidance from Inter Aide, a French NGO, to start its health insurance scheme.

Key statistics of Annapurna health insurance program from 2011 to 2017 are presented in Table 2.

Table 2: Key Statistics of APVS, 2011–2017

Year	Members	Claim Fund (Rs)*	Claims (Rs)	Claims paid % of Claim Fund
2011	84,401	5,887,733	5,114,610	87%
2012	110,069	8,022,545	6,032,658	75%
2013	112,382	8,873,355	7,262,265	82%
2014	161,564	12,752,921	10,115,944	79%
2015	168,518	13,490,810	12,422,543	92%
2016	191,762	16,227,164	11,049,358	68%
2017	230,952	18,660,145	14,216,826	76%

Source: Annapurna Website http://www.annapurnapariwar.org/microinsurfin.html. Accessed on August 29, 2017.

* Claim Fund equals 65 percent of total premium, and is the amount reserved to pay claims.

6. ENROLLMENT AND MEMBERSHIP

In the beginning, Annapurna Pariwar did not require its credit society members to enroll in APVS. Under this voluntary enrollment, about 3,000 members enrolled, less than 10 percent of total credit society members. Annapurna tried to increase enrollment through different educational programs and repeated meetings with members; however, most members remained unconvinced of the need for health insurance. Annapurna soon realized that maintaining the policy of voluntary enrollment would create adverse selection[7] and ultimately make the scheme financially unsustainable. Finally, through a democratic process of community consultation and resolution by community members, Annapurna made enrollment in the scheme compulsory for all members of the credit society in 2011.

Annapurna credit society has (as of March 31, 2017) 100,235 shareholders of which 60,940 are credit clients who hold health insurance policies. The majority of Annapurna policyholders have small businesses, and about 50 percent of members earn Rs. 15,000 or less per month (Annapurna Programme Evaluation notes).

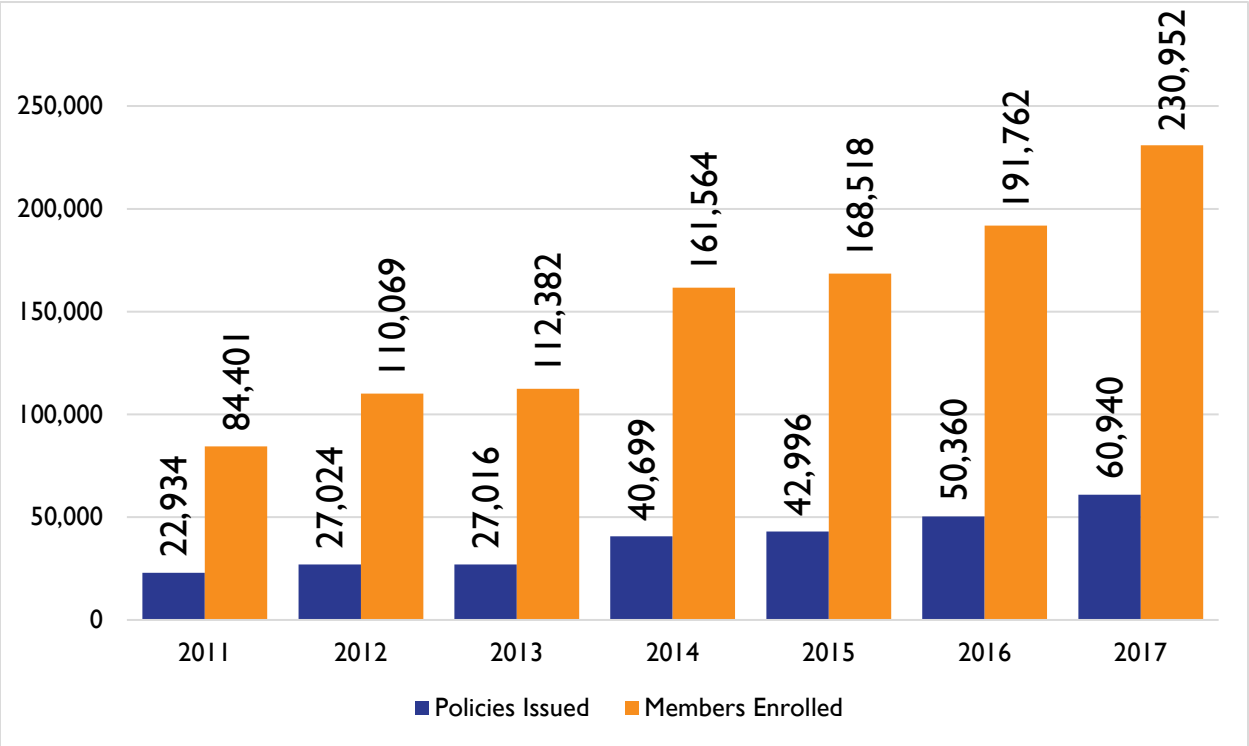
Enrollment of family members remains voluntary. Annapurna recognizes that enrolling family members requires client education. To encourage family enrollment, Annapurna offers an incentive: a discount in the premium of about 13 percent. The regular annual premium is Rs. 150 per person. If the borrower joins with three or more family members, the premium drops to Rs. 130 per person. Annapurna has set a target of four enrollments per family and current enrollment suggests that they have achieved 3.8. Almost every borrower joins with family; less than 1 percent are single members.

Annapurna initially feared that making health insurance compulsory for the members of the credit society would lead to a drop in membership for the credit product, especially because there are alternative credit programs.[8] But the opposite happened: credit society membership tripled between 2011 and 2017, from 22,934 to 60,940, and had a compound annual growth rate (CAGR) of 18 percent; the total loan outstanding increased more than six-fold, from Rs. 134 million ($3 million) to Rs. 810 million ($12.45 million); and the re-loan ratio reached 80 percent. As a result, APVS membership and the percentage of credit society members participating also increased. By March 2017, APVS covered 230,952 members under 60,940 policies (see Figure 1). The introduction of Maharashtra government's health insurance schemes for families below the poverty line in 2013 did not have much impact on the growth in membership. In fact, Annapurna believes that health insurance has had a positive effect, attracting clients to the Annapurna credit product.

[7] Adverse selection occurs when younger and healthier people fail to enroll and a disproportionate number of individuals with health problems or health risks buy health insurance; ultimately, adverse selection can lead to claim costs that exceed premiums, making the insurance scheme financially unviable.

[8] Annapurna competes with 10 MFIs in Mumbai and Pune.

Figure 1: Policies Issued and Members Enrolled, 2011–2017



Making enrollment in health insurance mandatory has other benefits. Because Annapurna does not have to separate the insured from the non-insured, administrative costs of promotions and enrollment are lower, and the savings can be focused on informing and educating members and on risk management. Having the larger insured pool mitigates the problem of adverse selection (McCord and Roth 2006). Annapurna also leverages its strong social capital to attract members who, even in a low-income market setting, trust that Annapurna's insurance programs will meet their health risk protection needs.

As alluded to above, member education remains crucial to the success of the mutual. Annapurna has dedicated Service Executives (SEs) to promote the program and impart heath education, which helps in reducing claims. SEs meet with members during fortnightly visits to loan offices; they inform and educate members about their entitlements and lend assistance in filing claims.

7. PRODUCT DESIGN AND FEATURES

APVS members elect Community Representatives (CRs), who form the CR Committee. The committee makes various decisions related to the implementation of the mutual health insurance program. A key aspect of APVS is that every design decision is discussed and passed by resolution in CR meetings. The feature is then incorporated into program design.

Annapurna Pariwar loan tenures vary from 18 to 36 months, while health insurance policies are for one year. To synchronize these two periods, Annapurna has developed three types of policies: a full-term policy, a partial renewal policy, and an auto-renewal policy. If the loan period (in months) is a multiple of 12, a full-term policy for each 12-month period is issued to members. If the loan period is for a period of 18 months, a partial renewal policy for six months is issued after completion of the one-year policy. The auto-renewal policy is a bridge policy of less than six months, for those whose loan term has ended and are applying for another loan; its premium is charged proportionately. The objective is to ensure that members are covered for the full loan cycle.

APVS provides a range of benefits to its members. This includes benefits for hospitalization (up to Rs. 18,000 per person per year), consultations, follow-up, and medicines. In specific cases, certain pre-hospitalization services and charges for "one-day discharge" and day-care treatment at network outpatient departments are also covered (Debnath 2016). In addition, members seeking outpatient care get health advice, health check-ups, referrals, and outpatient care for diagnostics, consultations, and medicines at discounted prices.

The community-managed mutual health program operates on principles of solidarity and proactive control on claims, which helps keep premiums at affordable levels. There is no third-party engagement in their under-writing process.

The annual premium is collected upfront on the day the loan is disbursed, and a separate receipt is issued for the premium payment. Staff explain to members how much they are paying for the premium and the benefits of the scheme.

8. CLAIMS MANAGEMENT AND SETTLEMENT

Unlike the national and state government "cashless" insurance programs referred to earlier, Annapurna Pariwar, after careful deliberations and consideration, chose to adopt a reimbursement-based design. APVS members agree with this choice, feeling that it makes members cost-conscious and allows CRs to discuss and weed out unnecessary costs and fraud. The health insurance literature suggests that higher financial barriers, even short-term ones embedded in reimbursements approach such as in case of Annapurna, may reduce access to health services. Still, Annapurna thinks that despite the low-income standing of these communities, a reimbursement-based insurance scheme has not affected members' health seeking behavior.

Annapurna recognizes that one measure of a health insurance program's success is the claims turnaround time. The claims process should be simple and fast to address member's needs and quickly issue reimbursements, which can also help mitigate catastrophic health expenditures (Rendek et al. 2014). Annapurna has developed performance benchmarks for claim processing: the claim documents must be submitted within 15 days of the member's discharge from the hospital, and the claim must be paid within 60 days of submission. It recognizes that current experience of Annapurna members, of a 75-day claim settlement period, may pose challenges to the effectiveness of the insurance program because the irregular cash flow of many members may not accommodate the period between when they must pay for care and when they receive reimbursement.

Once a member submits a claim, the Claim Scrutiny Executive initiates claim processing in the branch office. From the branch office of Annapurna, the claim is registered using customized software. An Annapurna Medical Office reviews the claim for medical relevance, line of treatment, cost of treatment, and category of service provider.

Negotiated payments vary by provider. To encourage members to use public health facilities, members using such facilities are eligible for reimbursement of 100 percent of the allowable amount of the claim. Members using trust hospitals are eligible for reimbursement of 70 percent of the allowable amount, and they must pay the remaining 30 percent OOP. Those using networked and designated private providers are eligible to receive 50 percent of the allowable amount. Treatment sought in a non-network private hospital is not covered, except in emergency cases. Annapurna tracks member use of public, private, and network hospitals. In Mumbai, half of the hospitalized members use public facilities. In Pune, the use of public facilities is less.

Once the Claim Scrutiny Executive and a Medical Officer have completed the document and medical validation of the claim, the full CR committee makes the final decision on claim reimbursement. These decisions are made on the seventh of every month, for an average of 289 claims. The average cost paid per claim was Rs. 4,098 in 2016-17 Claims above Rs. 18,000 number one or two per year.

Although community members, through their representatives on the CR Committee, actively participate in the settlement of claims and decide on final reimbursements through a democratic process, the process is not free of tension. Conflicts sometimes arise, particularly when a claim is rejected. In such situations, senior officials engage with the concerned member/s and explain reasons for the claim rejection.

9. HEALTH CARE PROVIDERS SERVICE AND QUALITY

A health insurance program per se cannot fully mitigate financial burden unless it ensures service delivery quality and controls provider-induced moral hazard (McCord and Roth 2006, Rendek et al. 2014). Annapurna Pariwar aims to do both by vetting and empaneling hospitals and other health care providers. Annapurna has developed guidelines for the empanelment of private providers in the APVS network; it has signed Memorandums of Understanding with 137 private hospitals and letters of associations with public and trust hospitals. These agreements include negotiated rates of reimbursement for services provided to APVS members.

Members pay the negotiated rate at the point of service. Because these rates are lower than what the general public pays, the member realizes savings. Of course, as explained above, the member is reimbursed at a rate that varies depending on the type of provider used (public, trust, and private) and so the member may incur some OOP spending.

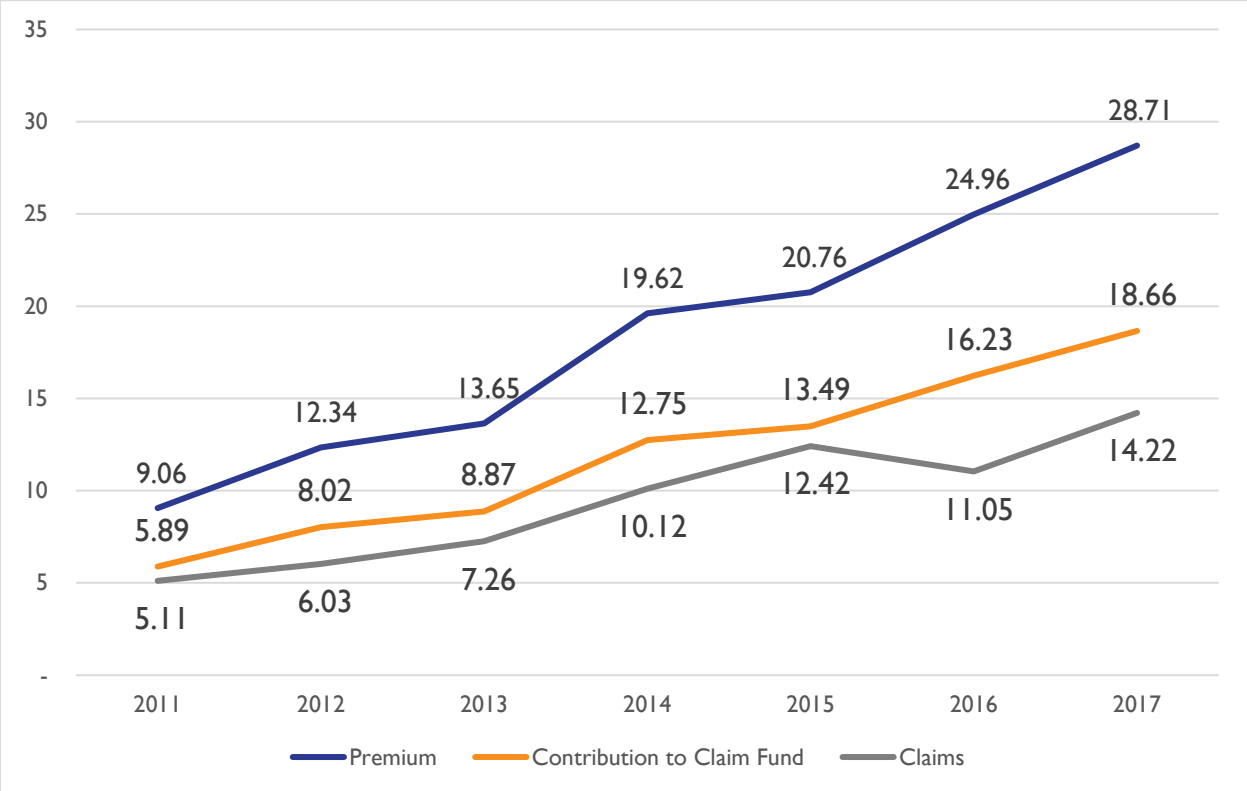
Annapurna solicits routine feedback from its members on quality of services provided at the empaneled health facilities. It has removed two networked health facilities from the empaneled list for fraudulent practices.

10. RISK MANAGEMENT

Annapurna has received about 289 claims per month thus far in 2016-17, and it has paid out Rs. 14.2 million on a total of 3,469 claims. This number of claims is about 1.5 percent of total members enrolled for health insurance. The rejection rate of claims has been less than 1 percent, and the ratio of claims to contribution to claims fund[9] 76 percent (see Figures 2 and 3). The approval process generally examines several aspects of the claim such as whether the member had sought information about the options for care, type of provider selected, and verification of health facility used.

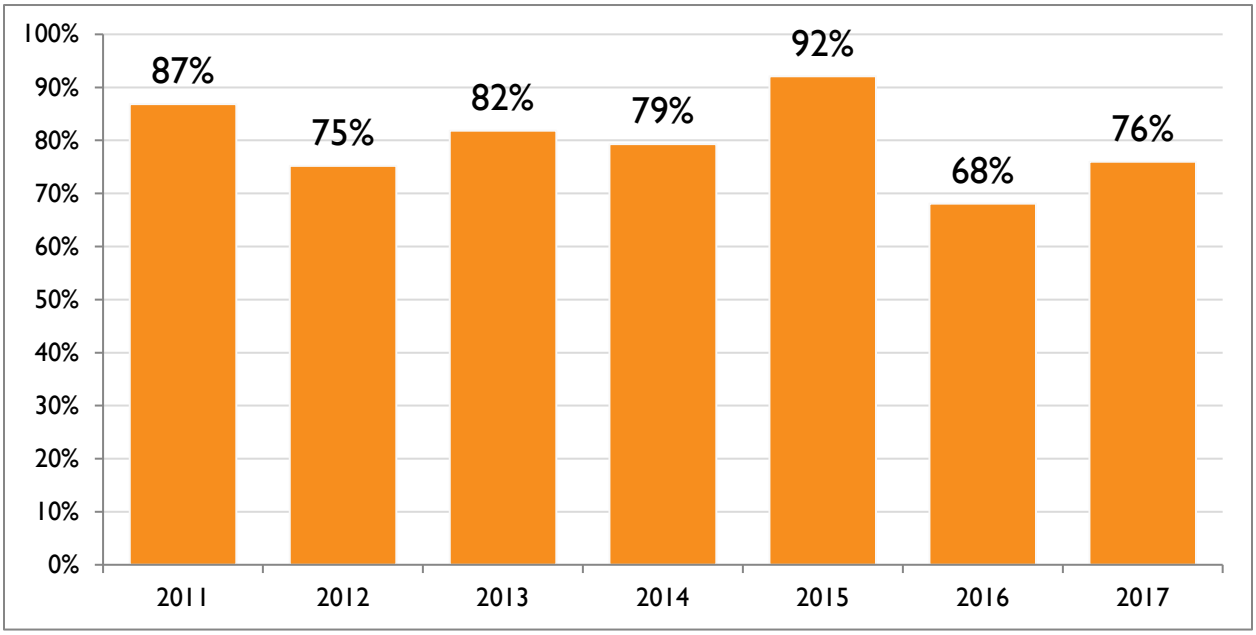
From the beginning, the organization has emphasized use of IT to manage claims and risks. The customized software developed through technical and actuarial assistance from Inter Aide has been pivotal in scheme administration and risk management. This software has been revised and updated five times and is now stable. Annapurna considers the software critical to its success – it has helped Annapurna to integrate credit and health insurance enrollment and claims management systems, to do a branch-wise analysis of earned premiums and claims so that it can identify surpluses and deficits at the branch level, and to provide cross-branch support when situations of non-availability of funds arise.

Figure 2: Premium, Contribution to Claim Fund and Claims (Rs millions)



[9] Contribution to claim fund is 65 percent of total premium received and 35 percent is earmarked for administrative expenses.

Figure 3: Claims Paid as a Percentage of Claim Fund



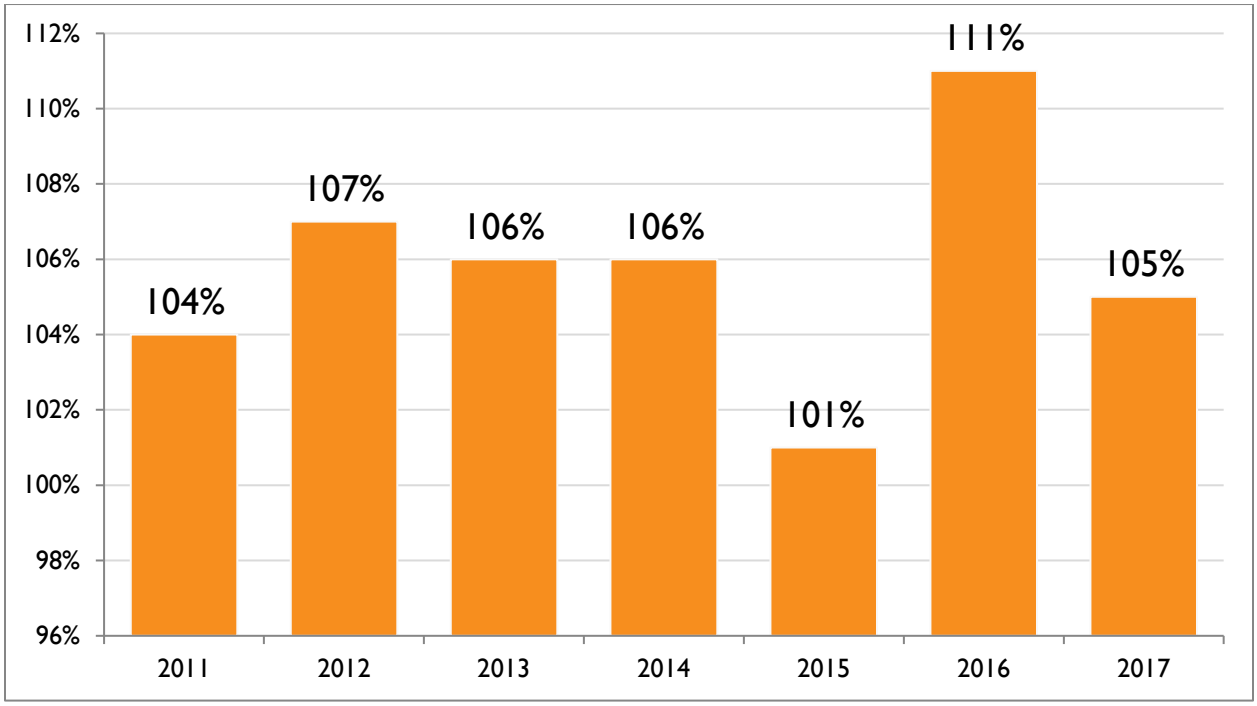
Effective risk management means that an insurance scheme can maintain adequate reserve funds (IRDA recommends a solvency ratio of 1.5) to meet all financial obligations arising out of claim costs and administrative expenses and support smooth insurance operations. In commercial insurance, any surplus, after paying claims and administrative expenses, is part of company profits. However, since Annapurna is a Section 8 company, any surplus goes to a "balance fund" at the organizational level for use if current premiums are not adequate to meet claims and administrative expenses. This fund is important, since mutuals do not depend on capital from external sources and, as a matter of principle, avoid borrowing or taking donations in case of a deficit. Annapurna has accumulated a balance fund of about Rs. 18.66 million, which is about 1.3 times the cost of claims in 2017.

Annapurna manages risk as follows. First, the premium is maintained as a liquid account at each branch, and the balance fund is accumulated as a fixed account at the organization level. The IT system maintains the premium amount for each branch. Each month, any surplus is transferred to the balance fund. If in any month the premium amount falls short of claims expenses, then the branch-level claim disbursement committee follows a three-step process: (i) reduce all remaining claim payment for the period to a maximum of 60 percent of the allowable benefit, (ii) determine if other branches have a surplus income in that month that can be used to pay the branch's deficits, and finally, (iii) use the balance fund to pay the pending claims.

11. ADMINISTRATIVE EXPENSES AND OPERATING SELF-SUSTAINABILITY

Annapurna deposits 35 percent of collected premiums in a separate account to meet administrative expenses. Administrative costs generally are those of staff (e.g., salaries, training), buildings and equipment, IT software and hardware, maintenance, utilities, and other operational costs (e.g., paper, printing material). Annapurna calculates the operating self-sustainability (OSS) ratio by dividing the 35 percent of premium collected (amount earmarked/targeted for administrative expenses) by actual administrative expenses. A ratio above 100 percent indicates that funds spent on administrative expenses are less than the funds reserved for administrative expenses and shows the extent to which Annapurna's administrative expenses match its target of 35 percent of total premiums. In all the years since 2011, the overall OSS ratio has exceeded 100 percent.[10] In 2016, this ratio was at its highest at 111 percent (see Figure 4). To get an idea about the viability of the health insurance scheme, Annapurna suggests looking at two measures: (i) claim to contribution to claim fund ratio, which should be less than 100 percent, and (ii) OSS ratio, which should be more than 100 percent. In all years since 2011, both these ratios are favorable.

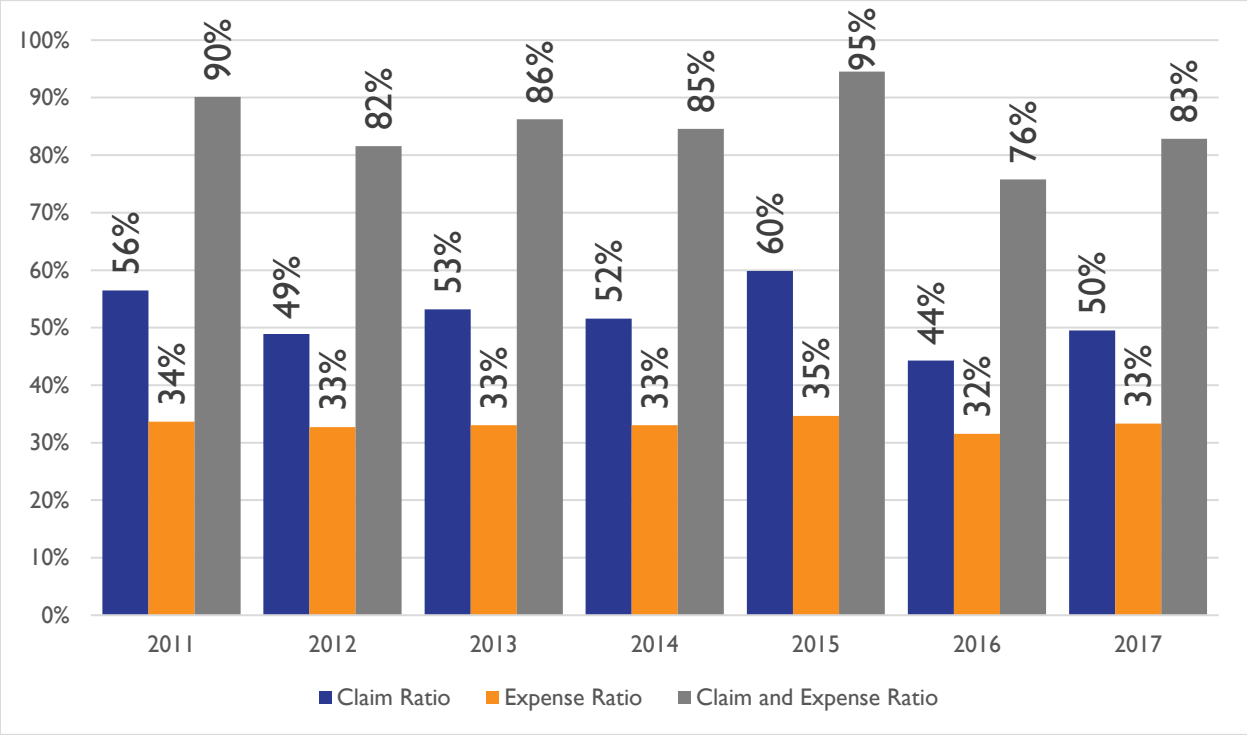
Figure 4: Operating Self-Sustainability



[10] The overall OSS ratio is provided for all APVS programs, which include life insurance and pensions besides health insurance.

The viability of the scheme can also be viewed using the claim ratio (claims paid to total premium) and expense ratio (total administrative expenses to total premium). Figure 5 presents the behavior of these ratios for the years 2011 to 2017. Notably, the expense ratio is based on aggregate data for three components of the AVPS program: health, life, and pensions. Since most of Annapurna's administrative expenses are joint costs incurred to operate the health, life and pension programs, it is difficult to segregate data by line of business. Annapurna management suggests that it is possible that administrative expenses of the health program are higher than those of other programs, but also feels that the administrative expenses are likely to decrease with scale-up of the program.

Figure 5: Claims and Expense Ratio, 2011–2017



Note: Expense ratio calculated based on aggregate of health, life, and pensions program.

12. OTHER RISK MITIGATION EFFORTS

Annapurna recognizes that financial literacy programs and preventive and health promotion initiatives can help mitigate risk and reduce claim costs. Adverse selection risks are mitigated through mandatory enrollment of members who borrow from the credit society. In addition, 99 percent of members opt to insure their family members.

Annapurna Pariwar has taken various steps to minimize financial burden arising because of illness of members.

Annapurna has negotiated discounted rates for consultation, medicines, and diagnostic tests with empaneled outpatient providers. It also has negotiated rates with standalone diagnostic centers and pharmacy shops; the discounts range from 10 percent to 30 percent. The objective of this strategy is to reduce the OOP spending on outpatient care and encourage health-seeking behavior at early stage.

In addition, Annapurna employs two full-time medical officers. Members can receive free health check-ups at Annapurna offices for non-emergency cases. The medical officers provide members with free guidance about how to access care. This guidance is provided through the 'round-the-clock' helpline and during fortnightly visits to branch offices. This helps members take appropriate steps at the time of seeking care and to select networked facilities having good track record. Members are advised to call the helpline before seeking services at any facility. However, only about 58 percent of members call before being admitted to a hospital.

Annapurna makes a special effort to train its low-income members about various financial products, enabling them to look to the future and adopt more efficient mechanisms to handle cash and information. Moreover, as the scheme works through credit group members, there is a higher chance of correct and complete information about family members in terms of name, age, relationship, gender, and history of illness. If these pieces of information were found to be false, benefits would be cancelled without returning the contribution.

13. GOVERNANCE STRUCTURE AND SOCIAL CAPITAL

Annapurna Pariwar's micro-insurance is structured along the lines of other CBHI schemes and is registered as a Section 8 company (not-for-profit) under the Companies Act of India. The Insurance Regulatory and Development Authority of India (IRDA)'s regulation of micro-insurance suggests a partner-agent model of health micro-insurance, and the guidelines do not make reference to the mutual health insurance model. Annapurna is of the opinion that since it is not an insurance company in the legal sense and as it does not participate or engage with any insurance company as an agent, the regulations do not apply to it.[11] Nevertheless, it has designed its mutual health insurance program to ensure other regulatory compliance pertaining to credit functions.

The health insurance program of APVS is managed through the CR Committee, composed of 70 CRs (38 from Pune and 32 from Mumbai) elected by members in the community meetings. CRs serve a two-year term, on a voluntary basis. Community level CR meetings take place on the seventh day of every month. This regular schedule ensures strong community participation and trust in scheme management. During the meeting, CRs make decisions on claims based on established eligibility criteria, and on other matters regarding the health mutual.

Each branch servicing 2,000 to 3,000 loan holders has one SE, whose role is to promote different insurance products (including life and pension products). The SE receives a fixed salary plus variable pay linked to performance. Incentives are structured such that there is a strong motivation to meet different service quality timelines in the scheme. One Service Manager supervises three SEs.

Because the scheme is community driven, it is familiar with the health and economic status of its members. The information comes from two sources: (i) the elected community representatives, and (ii) field staff and medical doctors who check medical details of each claim. Annapurna's greatest strength is its members. Annapurna believes that there is a complete ownership of the community leading to transparency and thus very high client satisfaction.

[11] As per IRDA regulations, the capital requirement of setting up a commercial insurance company is Rs. 1 billion.

14. KEY CHALLENGES AND THE WAY FORWARD

All insurance programs face potential risks, primarily adverse selection, cream skimming, moral hazard, free riding, and fraud. These risks are well documented in the insurance literature (Dror et al. 2009). Annapurna Pariwar believes it has designed a program with features to mitigate these risks. For example, making the program mandatory for all credit members mitigates the risk of adverse selection, cream skimming, and free riding; a rigorous vetting and empanelment of network providers militates against provider moral hazard and fraud. That said, like other CBHI schemes, Annapurna continues to have a small base of members concentrated in the two communities of Pune and Mumbai – this does not give it adequate scope and opportunity to diversify risks, resulting in high covariate risk.[12]

14.1 Which insurance model should be used?

A member-designed and member-managed health care financing model based on principles of mutuality offers an attractive alternative to the dominant partner-agent approach to micro-insurance in India. However, lack of scale and appropriate diversification, high covariate risks, and lack of reinsurance[13] in a mutual or CBHI model makes it vulnerable to failure in the event of combined claims and administrative costs that exceed revenue. Thus, some NGOs and MFIs have adopted a hybrid approach that offers health insurance products on the basis of both the mutual model and the partner-agent model in partnership with a licensed insurance company. For example, under the hybrid approach, a primary health care insurance product could operate on a mutual model and a hospitalization product could operate on a partner-agent model. Is such a hybrid approach the best way to scale up?

14.2 How the benefit package can be expanded affordably?

Some argue that insurance schemes that cover only hospital expenses are inadequate in protecting the poor against impoverishment, due to other expenditures the poor still must make on health (Shahrawat and Rao 2011). A broader benefit package, which includes medicines and outpatient care, is necessary to reduce OOP spending significantly and protect from impoverishment, as well as improve health outcomes.

Complete integration of primary care into any mutual health program at an affordable level remains a challenge. There is a significant felt need by Annapurna Pariwar's management to integrate primary care into their mutual health insurance program. Early intervention strategies like primary care also may help in reducing and controlling future health care expenditures.

[12] Covariate risk occurs when the probability of contracting a communicable illness increases when neighboring households experience same illness, i.e., in situations of localized epidemics.
[13] Reinsurance is insurance that an insurance company purchases from one or more insurance companies (the "reinsurer") directly or through a broker as a means of risk management.

As discussed, Annapurna has taken some basic steps in integrating primary care through negotiating discounts from various primary care providers (consultations, pharmacies, and diagnostic centers) and enabling members to get discounts ranging from 10 to 30 percent by showing their Annapurna membership card. The program has also developed a mechanism to cover one-day discharge and day care treatment to avoid episodes of illnesses that do not require hospitalization being converted into hospitalization cases (a form of moral hazard to access benefits). However, it needs to include overall primary care in the benefits package.

Annapurna has expressed the will to do this, but in order to properly design and implement such a package it might need technical assistance in areas such as (i) determining the nature and profile of outpatient care needs, (ii) capturing data on outpatient service utilization, and (iii) based on the data, examining affordability, then developing and integrating primary care benefits into the existing program. Since members already spend out of pocket on outpatient care, and given Annapurna's experience in developing a provider network and claim management system, Annapurna thinks it will be able to achieve this integration in the next three to four years.

14.3 Can the reimbursement approach be quicker?

Another challenge is APVS's use of the reimbursement model. Currently, members who receive services have to pay at point of service and then bear the financial risk for an average two months before they receive reimbursement. While Annapurna management believes moving to a cashless system is not appropriate because this would increase administrative costs, it feels that the scheme should reduce claim turnaround time to less than one month. One option is to modify the claim adjudication process so that it can reimburse beneficiaries within one week of discharge. However, questions about the implementation of such a process remain. For example, how can the time taken by the CRs and medical officers to process the claims be reduced? How long will the CRs be engaged in handling claim management? Is it sustainable in the long run?

14.4 Should the health mutual program complement or compete with government schemes?

As suggested by the membership data of credit members and policies enrolled, the introduction of government-supported health insurance schemes for populations living below the poverty line did not affect the growth of APVS. Annapurna caters to a different client base, which is the population just above the poverty line. In fact, Annapurna managers advise poorer members to apply to the government schemes whenever possible, because some of these members may qualify for the government schemes. APVS members use government facilities, and they are eligible for full reimbursement for doing so.

14.5 Should the scaled-up health insurance program be offered through an MFI?

Is being an MFI a strength or burden for the health insurance program? APVS started as a voluntary health mutual scheme that later was made mandatory for borrowers in Annapurna Pariwar's microcredit program. This raises the following design questions: (i) would the scheme be sustainable if it were voluntary, and not mandatory? (ii) would being voluntary affect sustainability if non-members of the microcredit program could enroll in the health scheme?

As discussed earlier, making enrollment in APVS mandatory for Annapurna's credit clients led to a rapid scale-up of the health insurance program, and it continues to help reduce administrative costs and risks. Specifically, it helped improve the APVS coverage ratio from 10 percent in 2006 to 67 percent of all credit society members in 2017. However, the insurance scheme currently focuses on enrollment of members of the credit program only, limiting the pooling and sharing of the financial risk. In the long run, Annapurna eventually would need to devise a strategy to expand and enroll non-credit members in its health mutual program to achieve greater scale.

Scaling up to new geographies and other population groups and poses challenges, but they are not insurmountable. As has been noted, Annapurna credit society operates in Pune and Mumbai. It competes with the credit programs of 10 MFIs in Pune and about 15 MFIs in Mumbai, and so selling the credit society-linked APVS would be difficult there. However, Annapurna has decided to work with MFIs through a franchise model in three other regions: Beed, Kolhapur, and Marvel. It is willing to help any other MFI that is not a competitor in its existing catchment area for credit. It also could expand to different population groups, for example, small and medium industry clusters, migrant groups, and urban labor markets. These options are discussed in detail in Bhat et al. (2017).

Annapurna management feels it knows how to scale up and has appropriate technology in place but would like to have partners who believe in mutuality and place health insurance high on their agenda. Annapurna feels that IT would play an important role in scale-up. Annapurna's software could be used by other mutuals with a very small investment, less than Rs. 12 per annum per member, and it believes that this cost can further be reduced. In addition, the support required to put the program in place is one doctor to begin with and one SE per 1,000 members.

Given the performance of Annapurna, the health mutual model may hold promise for meeting the needs of India's near-poverty line population in a sustainable way. However, APVS is in a nascent stage of development and its reach is currently limited to members of the society. There are also enormous regulatory and operational challenges; current micro-insurance regulation in India does not make explicit reference to the health mutual insurance model. Still, APVS offers important lessons on what works and what further improvements can be envisaged to overcome key challenges for the program.

15. SUMMARY

This case study has reviewed the genesis and development of the mutual APVS health insurance scheme that Annapurna Pariwar implemented to protect its credit society members from financial barriers to hospital care. The case discusses the risk management model that APVS adopted and the strategies it implements to create value for its members. The case contributes to an understanding of how a credit group developed a community-led mutual health insurance program to provide its members financial protection from some health care risks and promote appropriate access to care. It also provides insights into the dynamics of microcredit markets, which pose a challenge to scaling up the program to other members of the community despite a huge untapped market. Essentially, this is because credit societies compete for credit market share in same geographic regions, and they are not willing to extend the health insurance products to members of other credit societies. Inability to delink the credit market and health insurance services limits scheme scale-up. The case suggests the way to expand the base and reach more credit and non-credit clients is to collaborate and partner with MFIs that are in a different region(s) and that do not compete in the same credit market. Also discussed are topics such as exploring affordable options for expanding the current hospital benefits package and making the program more comprehensive by covering outpatient care, strengthening the claim processing process, leveraging technology to reduce administrative costs, and focusing on other population segments. Given that MFIs in India have a client base of 40 million members and potential to reach 150 million, this case demonstrates that this model has potential to be developed and implemented to cover the health risk of communities and reduce high OOP spending on health. The promotion of these approaches can play a pivotal role in achieving UHC goals.

ANNEX A: DIFFERENCE BETWEEN A PARTNER-AGENT MODEL AND MUTUAL/COOPERATIVE INSURANCE MODEL

To promote health insurance among the economically vulnerable populations, IRDA recognized micro-insurance as a special category of insurance in 2005. The rules and regulations of micro-insurance products were changed in 2015. The new rules paved the way for larger participation of CBHI schemes in the distribution of micro-insurance products including those offered by cooperatives registered under the Cooperative Societies Act, MFIs, and self-help groups.

The "Partner-Agent" model

In the"partner-agent"model, the pricing of micro-insurance products remains with the insurance companies and the micro-insurance product is sold, distributed, and serviced by an agent. Many CBHI schemes use this model of selling and distributing insurance products. Distribution channels are typically MFIs, but innovative alternatives include retailers, utility and telecommunications companies, and third-party bill payment providers. All of these distribution channels have some tie to the low-income population. The introduction of micro-insurance also motivated commercial insurers to seek partnerships with MFIs and NGOs to act as agents. Partnerships between formal risk carriers and microfinance programs are aggressively promoted by formal health insurance companies in India to expand insurance coverage among the poor in rural areas. The commercial insurance companies found the micro-insurance system suitable as it helped them to meet the statutory obligation on the unorganized sector to cover risks of economically vulnerable sections of the population.

Mutuals, cooperatives, and other community-based models[14]

In the mutual model, the community has an important role in designing and managing the program. The insurer is owned by clients (members), who share in the program's benefits and costs, often with members' liability limited to their premium contributions. Cooperative insurers may, but need not, be owned by clients. These models have similar characteristics, including involvement of insurance clients in management, and often serve pre-existing groups of clients, such as borrowers from a credit and savings cooperative or MFI, or residents of a limited geographic area.

Lending organizations often offer borrower's insurance contracts that cover the balance of a loan. They also often offer life insurance, and sometimes provide housing, funeral, invalidity, and accident and health policies. These products come in addition to mainstream credit and savings services.

For more details see: Bhat, Ramesh, Lysander Menezes, and Carlos Avila. August 2017. Review of Community/Mutual-Based Health Insurance and Their Role in Strengthening the Financial Protection System in India. Bethesda, MD: Health Finance and Governance Project, Abt Associates Inc.

[14] Source: http://www.microinsurancenetwork.org

ANNEX B: THE FIVE MEMBER ORGANIZATIONS OF ANNAPURNA PARIWAR

Annapurna Pariwar started by lending Rs. 9,000 to a group of nine vegetable vendors. Over time, it began offering a need-based package of services to low-income groups. Annapurna Pariwar now has five independent developmental organizations working under it.[15] Micro finance products offered by the Annapurna Pariwar Group includes services like micro-loans, micro-savings, micro-insurance, and Adharpurna old-age savings program.

1. Annapurna Mahila Multi State Cooperative Credit Society Ltd is a multi-state credit cooperative society that gives small repetitive loans to poor self-employed women and men who form joint liability groups. Microfinance loan amounts vary (from Rs. 10,000 to Rs. 500,000) based on the purpose of the loan; they usually are given for business, education, house repairs, asset creation, and repayment of existing debt. Loans are given without any security or guarantee but enjoy a 100 percent recovery rate.
2. Annapurna Pariwar Vikas Samvardhan (APVS) is a not-for-profit company, owned and run by the members of Annapurna Mahila Multi State Cooperative Credit Society. APVS offers separate products for health insurance, life insurance, and pensions. Health and life insurance is mandatory for borrowers. APVS recently started an old-age security program for members older than 65 years.
3. Vatsalyapurna Service Coop Society runs day care centers for the children of domestic servants and other self-employed women in slums.
4. Annapurna Mahila Mandal, Pune, implements the Vidyapurna (complete education) Project and gives scholarships to children of single mothers (widows/destitutes/divorcees) so that the children can pursue their education and have a better future.
5. Annapurna Mahila Mandal, Mumbai, runs the Working Women's Hostel at Vashi, New Mumbai.

[15] Source: http://www.annapurnapariwar.org/

ANNEX C: DIFFERENCE BETWEEN A TRUST, SOCIETY, AND SECTION 8 COMPANY

A non-profit organization can be registered in India as a Trust (public or private), Society, or Section-8 Company. Trusts are the oldest form of charitable organizations. However, private trusts are formed for the benefit of family members, or a very small set of known persons; they are not charitable trusts. Key differences between the three types of not-for-profit organizations are summarized in the table:

S. No.	Basis of Difference	Trust	Society	Section 8 Company
1	Statute/ Legislation	Governed by the Indian Trust Act, 1882.	Governed by the Societies Registration Act 1860, an all-India Act. Many states, however, have variants of the Act.	Governed by the Indian Companies Act, 2013.
2	Jurisdiction over registration	The trusts are under the jurisdiction of Deputy Registrar/Charity Commissioner of the relevant area.	The power to register a society lies with Registrar of Societies (charity commissioner in Maharashtra).	The power to register a Section 8 company lies in the hand of Regional Director and Registrar of Companies of concerned state.
3	Registration document	Main instrument is Trust deed.	Main instrument is Memorandum of Association and rules and regulations.	Main instrument is Memorandum and Articles of Association.
4	Stamp duty	Trust deed to be executed on non-judicial stamp paper, vary from state to state.	No stamp duty required for memorandum of association and rules and regulations.	No stamp duty required for memorandum and articles of association.
5	Members required	At least two trustees are required to register a public charitable trust. In general, Indian citizens serve as trustees, although there is no prohibition against non-natural legal persons or foreigners serving in this capacity.	Minimum: - Seven members required for formation of state-level society. - Eight members required from separate states for formation of national-level society.	Minimum 2 for a private company and 7 for a public ltd company.
6	Management	Trustees or board of trustees.	Usually a governing council or managing committee.	Board of directors.
7	Legal title	Vests in the hands of trustees.	Held in the name of the society.	Held in the name of the company.

S. No.	Basis of Difference	Trust	Society	Section 8 Company
8	Revocable/ Irrevocable	Indian public charitable trusts are generally irrevocable.	Societies may be dissolved. Dissolution must be approved by at least three-fifths of the society's members.	A Section 8 company may be dissolved.
9	In case of inactivity	If a trust becomes inactive due to the negligence of its trustees, the Charity Commissioner may take steps to revive the trust. Furthermore, if it becomes too difficult to carry out the objects of a trust, the doctrine of *cy pres*, meaning "as near as possible," may be applied to change the objects of the trust. Thus, it appears that grantors can feel fairly secure that the charitable nature of a trust will be honored, even if the original, specific purposes cannot be carried out.	Upon dissolution, and after settlement of all debts and liabilities, the remaining funds and property of the society may not be distributed among the members of the society. Rather, they must be given or transferred to some other society, preferably one with similar objects as the dissolved entity.	Upon dissolution and after settlement of all debts and liabilities, the remaining funds and property of the company may not be distributed among the members of the company. Rather, they must be given or transferred to some other Section 8 company, preferably one with similar objects as the dissolved entity.
10	Annual compliance	Filing of annual return is not required.	Societies must file annually, with the Registrar of Societies, a list of the names, addresses, and occupations of their managing committee members.	Accounts and returns of company must be filed annually with Registrar of Companies
11	Online filing facility	No online filing facility available, making compliance complicated and time consuming	No online filing facility available. Everything must be submitted in the office of Registrar of Societies in hard copy, making compliance complicated and time consuming.	Online facility available. Compliance requirements, like annual filing, appointment and removal of directors, shifting of registered office, increase in capital, and change in object clause, can be done online at MCA portal. It is an easy, time-saving, and transparent process.
12	Time period involved in registration	10-15 days	30-45 days	60-75 days
13	Cost of registration	Low	Medium	High

S. No.	Basis of Difference	Trust	Society	Section 8 Company
14	Registration with Income Tax u/s. 12A & 80G as NGO	At par with society and Section 8 company.	At par with trust and Section 8 company.	At par with trust and society.
15	From point of view of grant of government subsidy	Less preferred	Less preferred	Most preferred
16	From point of view of Foreign Contribution Regulation Act, (FCRA) registration	Less preferred	Less preferred	Most preferred
17	Transparency of operations	Low	Low	High as everything is available online.
18	Change in board of directors/ trustees members	Easy	Complex	Easy
19	Change of registered office	Difficult	Difficult	Easy

ANNEX D: REFERENCES

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