Learning Journey

PWDS

Mainstreaming Access to Insurance Services for Rural Communities

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Project Basics

About the project

Palmyrah Workers’ Development Society (PWDS), started in 1977, is a development support organization offering programmes and support services that facilitate sustainable community initiatives through community organization, awareness generation, capacity building, and policy advocacy. PWDS uses an approach called MEALS -- Motivating and Mobilizing communities, Equipping them through skills transfer, Accompanying them with back up support, fostering Linkages with mainstream resources and Sustaining initiatives through community ownership, participation and empowerment. Their projects focus on income generation linking members to livelihood generating activities.

The project aimed to link insurers to a large rural populace through innovative channels of retail distribution and outreach for servicing rural clients. The project built on the existing resources and infrastructure of the NGOs supported by PWDS to develop an economically viable business model.

The project planned to distribute a cashless health product sold through Insurance Promoters (IP) and coordinated by an Insurance Coordinator (IC). The IPs are selected from the local community to ensure that they have some understanding of and credibility in the community. The product was initially sold to Federation members and then to other members of the community. Retail insurance sales channels were set up in three districts of Southern India to provide income for the IP, IC and Federation. More products can be added as the system stabilizes to promote sustainability of the channel.

Centre for Insurance and Risk Management (CIRM) was the learning partner for this project and assisted PWDS in conducting research and extracting lessons from project experiences.

Project Summary

<table>
<thead>
<tr>
<th>Project Name:</th>
<th>Mainstreaming Access to Insurance Services for Rural Communities</th>
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<tbody>
<tr>
<td>Project Start Date:</td>
<td>July 2009</td>
</tr>
<tr>
<td>Duration:</td>
<td>3 years</td>
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<td>Country:</td>
<td>India</td>
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<td>Product:</td>
<td>Health – in-patient</td>
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Project Updates

Key Indicators

Date of Launch: October 2009

<table>
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<tr>
<th>Indicator</th>
<th>July 2010</th>
<th>December 2010</th>
<th>June 2011</th>
<th>June 2013</th>
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<tbody>
<tr>
<td>Number of Federations participating</td>
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<td>7</td>
<td>7</td>
<td>5</td>
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<tr>
<td>Number of Federations where product is launched</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>5 (multiple products introduced)</td>
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<tr>
<td>Number of insurance companies</td>
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<td>2</td>
<td>4</td>
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<td>Number of launched products</td>
<td>1</td>
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<td>2</td>
<td>4</td>
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<tr>
<td>Number of beneficiaries (Families)</td>
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<td>17200 (7100)</td>
<td>17900 (7600)</td>
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<td>Number of Insurance Persons</td>
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<tr>
<td>Claims rejection ratio</td>
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<tr>
<td>Incurred claims ratio</td>
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What is happening?

As of September 2009

Based on feedback received from members on interactions with 4 insurance companies, a partnership was finalized with Bharati Axa General Insurance Co (BAGI). A preliminary needs analysis was carried out with BAGI among the community to support product development. This created a feeling of involvement for the community. The analysis indicated a need for an inpatient hospitalization cover to cover the cost of illnesses that could not be managed at home. Two options of the product, one with full payment of the claim with a higher premium and the other with a 20 per cent co-payment from the insured with a lower premium were developed. Surprisingly, prospective clients in focus group discussions preferred the co-payment option. This option was perceived as being less prone to false and excessive claims since a portion of the cost had to be borne by the claimant.

The project envisaged one more insurance company covering members in two other federations to enable a comparison of insurance buying behavior and assess the demand for insurance products that offer different covers. Two companies backed out of the project during the search for the second insurer.

Recruitment and training of IPs and ICs started. Processes for collection of premium from the members and passing them to the insurance company were developed. The mechanism for the insurance company to pay service charges to PWDS was worked out.
To mitigate adverse selection a Self Help Group was only allowed to join if 75 per cent of the members agree to enroll in the product. Though restrictive, this requirement aimed to prevent a situation where only unhealthy members would enroll.

**As of February 2010**

One health product was launched with BAGI in five federations. Close to 4,500 families and 12,000 members were insured.

Insurance was sold by the IPs and ICs who were assisted by the Federations and their staff in convincing the members to enroll. The trust built by the Federation over the years helped this process. The insurer’s field teams assisted and resolved queries as the enrollment process rolled out.

One interesting feature of the enrollments to this point was that four of the five federations and SHGs opted for the co-poly option.

HDFC Ergo General Insurance Company (HEGI) was selected as the second insurer on recommendation by Federation members. A project was developed for two additional federations. The product and processes were finalized and implementation was planned for July 2010.

**As of July 2010**

Enrollment continued in the five Federations. A total of 6,592 families with 16,501 members were enrolled. By this point a total of 40 hospitals in three districts had joined the network to provide cashless health care to the insured members.

Claims processes were refined but the high volume of claims put pressure on the premium for renewals.

A qualitative survey was conducted among the households to test their understanding of insurance and to identify any product or process features that might require modification.

At this point, the second insurer HEGI was yet to start operations due to internal constraints related to the readiness of the technology for enrolment, resulting in two Federations remaining unserved.

**As of December 2010**

The second insurer, HEGI, started operating in two Federations in November using a mobile phone-based enrolment process; this was a unique experiment in the country. The enrollment form is programmed onto the IC’s mobile phone and the details of the client are fed directly into the phone. These are uploaded onto a computer and transmitted to the central server of the organization for issue of cards and policy. Post initial hitches, the system worked well and helped reduce policy issuance time from 21-30 days to just 10 days.

Since the federation staff members are actively involved in the customer awareness and education programmes, and have strong relationships with the community members, the federations decided to try a modified process of using their staff for enrolments and premium collections, instead of separate IPs.
Unlike in the case of BAGI, HEGI did not have a clause of a minimum of 75 percent of SHG members joining the programme to mitigate adverse selection.

The first insurer, BAGI wanted to reevaluate the product, price and processes as the claims ratio reached 130 per cent. Pending approval of the revised parameters and pricing, BAGI stopped renewals of policies in September but continued to provide efficient service for the claims that were being reported. The Federations and the communities were very satisfied with the service being offered and wanted to continue with BAGI. They were open to a “reasonable” increase in premium despite options of other insurance companies being available. BAGI continued discussions on a modified product and pricing, and planned to start renewals and fresh enrollments as soon as possible.

One federation dropped out since there was a state government sponsored health insurance programme available and members taking loans from nationalised banks were being enrolled into it, thereby reducing the appeal of the PWDS programme.

As of June 2011

HEGI continued enrolments in the two federations and at this point had enrolled 1,050 families. In contrast to the experience with BAGI, nearly all members of one federation opted for the co-payment option whereas nearly all members of the other federation did not opt for the co-payment option. The process of mobile phone-based enrolments has helped further reduce the policy issuance time to six days. Only two new hospitals were added to the network. PWDS aimed to direct customers to specific hospitals in order to deliver higher numbers of patients to these hospitals and therefore negotiate better rates with them.

The Federations, PWDS and BAGI reached an agreement on a modified product with a premium increase of about 30 per cent. They then started work on an enrolment plan along with a renewal plan.

Since enrolments were delayed due to elections in Tamil Nadu, PWDS planned to conduct more workshops for the insurance sales staff and potential clients. PWDS, planned these workshops and trainings in collaboration with the Federations and the insurance companies.

As of June 2013

The Federations and BAGI relaunched the modified product with an increased premium of about 30%.

At the same time there were several rounds of discussions to resolve a few old claims that had been pending from the first version of the product. HEGI continued enrolment and servicing claims. The staff members had become well acquainted with the enrolment and claims product and started functioning as IPs. As a result, no further IPs were recruited. This helped the federations to improve their revenues from the insurance programme.

In 2012 federation members had started asking for opportunities to introduce additional insurance products like life insurance, simple personal accident covers and vehicle insurance. PWDS explored possibilities and adapted the insurance programme to include other products as a part of a larger
“livelihoods” package. Public as well as private insurance companies were approached and put in touch with the federations. Life Insurance Company of India, New India Assurance Company, National Insurance Company, Agriculture Insurance Company and Future Generalli Insurance Company offered their products and discussed processes with five federations.

The Federation members saw good value in the products being offered as they were more directly linked to their needs. As a result they chose to continue with these products and stopped offering the health insurance product at the end of the term.

**Status and way forward**

As a result of this project the federations have become familiar with insurance and it has become a mainstream activity for them. The federations’ employees have been trained and have become comfortable offering insurance. Insurance offers the federations a source of income and they are committed to offering it over the long-term.

As a part of the CRL programme (Climate change, Risk reduction and Livelihoods promotion), PWDS continues to support federations with their insurance programmes. Five federations now directly deal with insurers for their requirements using a partner-agent model under which the insurer maintains the risk and contracts a partner or agent to deliver the product and/or administrative services to the target market. The insurer also provides training to the federation staff and product awareness materials like posters, leaflets etc

- CPE (Center for People’s Education) became an agent selling General Insurance Products of New India Assurance Company and for LIC (Life Insurance Company’s) microinsurance policies. It sells life and personal accident policies.
- NJT (Nava Jeevan Trust) enrolled farmers in weather-based crop insurance (paddy) during the last winter crop season.
- TIPS (Team for Income Generation Programme) with Palma Federation became an agent selling general insurance products for National Insurance Company. It began selling health insurance in 2013. Two members of staff are dedicated to insurance products and TIPS has sold almost 5,000 life microinsurance policies on behalf of LIC.
- SEDCO (Scientific Educational Development of Community Organisation) became an agent selling general insurance products of Future General Insurance Company. It enrolls dairy animals and vehicles.
- RED (Rural Education for Development) sells LIC microinsurance policies to its members.

Personal accident, life, health, vehicle, crop, cattle insurance products have been introduced to meet the federation members’ requirements. Insurance has now become a part of the members’ set of tools for managing risk and is accessed as a financial planning tool.
Project Lessons

On the determinants of risk behavior and demand for insurance

The engagement and presence of personnel from the insurance company improves the confidence of clients during the enrolment and claims phases. Training was provided to the ICs and IPs and joint calls were made to prospective customers. Claims meetings were conducted in the field where the insurer’s claims team explained the procedure for filing a claim and the logic of how and why a particular claim has been settled or rejected. This gave communities confidence in the programme.

Endorsement from someone within the community who has received a claim has proved a powerful message. Settled claims provide an important demonstration effect for the community. A member’s husband was hospitalized with high fever and underwent treatment for 10 days with a bill of Rs. 16,000. When the member received a cheque for Rs. 12,000 from the insurance company within 20 days, the entire village knew about it and there was a spike in enrolments.

The IC came to be seen as the first point of contact for the insured. At the beginning of the scheme, it is therefore important for the IC as well as the IP to remain connected and involved, especially at the time of claims to coordinate between the insured and the TPA. The IC received calls at all hours from the community members since he was seen as the main link with the insurers. Since the IC was the known face, the claims documents were sent to him and he scanned and sent them on to the insurance company. The IC helped answer any queries or clarifications required by the insurance companies.

A complete understanding of on-ground conditions is critical prior to product and process development. This involves working with the communities and understanding their requirements rather than providing products that are available from the insurance company. The product features and pricing can be developed with the help of the community.

Involving local communities in the product development process and responding positively to observations and suggestions from the field helps build a connection with the community. Pre-product development meetings with the communities to understand the needs helped design and price the product, and gained early buy-in from the communities.

Furthermore, BAGI later reduced the documents required for claims authorizations in line with what was being actually given by the hospitals and what the claimants could provide. This facilitated explanations to claimants and built confidence in the insurance programme.

Educating clients and staff about document requirements can lead to improved claims performance. BAGI was able to settle claims quickly because the federations were diligent in submitting the documents to BAGI. The BAGI claims processing person used a case study method to explain the importance and relevance of each document required for claims processing to IC, IP and federation staff. This improved understanding and clarity about processes.
Providing efficient and transparent service enhances the claims experience and builds loyalty to the insurance service provider. The claims service provided by BAGI and its TPA was transparent. Clients were very satisfied with the claims processing, and because of this they were willing to wait for renewals, negotiate with BAGI, and pay an increased premium. This also shows that communities are willing to pay higher premiums if they are convinced of the benefits. Many clients were satisfied with the programme despite not having experienced a claim ever, because they had seen others receive claims payments.

On the impact of co-payments on the utilization of care and its implications

Members’ choice of the co-payment option suggests that members are willing to self-regulate. Contrary to expectations, four out of five federations where enrolments were carried out by Bharati Axa General Insurance opted for the co-pay option, which shows that members are willing to self-regulate. Even in the fifth one, where both co-pay and non co-pay options were used, most members chose the co-pay option. Members feel that requiring a co-payment will reduce the likelihood of excessive and false claims being filed since claimants have to pay a share of the costs. It is interesting to note that the same pattern was not observed with the two federations associated with the second insurer (HDFC Ergo); as members of only one federation opted for the co-payment option.

It also shows that communities and beneficiaries are capable of deciding what is “good” for them. This was shown in the process of selecting the two insurance companies and understanding and applying the concept of co-pay and coverage limits. They were always ready for co-pay and deductibles as long as they trusted that the insurance company would deliver on what it promised.

On effective delivery to rural clients through a retail distribution model

Regular training of IPs and ICs is critical. The IPs and ICs carry the message of insurance. They therefore need to be aligned with the project’s objectives, and their skills need to be enhanced constantly. The insurance company initially provides the product knowledge and sales training, but this needs to be constantly reinforced at the local level.

Incentives structures need to take care of expenses. Some IPs were spending a lot of money travelling to customers and so a decision was taken to introduce a fixed component in their compensation to cover this in addition to the percentage of commission.

Incentive mechanisms improve staff participation in enrolment. Since staff members of the federations had a long-standing association with the prospective beneficiaries, they were playing a significant role in helping the IPs and the ICs in consumer awareness, education and enrolment. An incentive mechanism was developed to take care of their interests and the time and effort they spent in the process. As a result they played a greater role in the enrolment process and have provided a great deal of support to the IPs. In the PALMA federation, for example, 80 per cent of enrolment is staff-assisted; and in the RED federation, all enrolment is carried out by federation staff. The staff has proven effective in building trust and in the in many cases has assumed the role of the IP. This not only gives them incentives but also earns an amount for the federation.
Federations play an important role in distributing insurance products. The role of the federations, and its staff, as community aggregators, has emerged as critical to providing the insurance experience to their members. They should be given the skills, knowledge and resources to allow them to play a role in improving the resilience of their communities to risks. They can be provided with appropriate technology tools and training to take over sales and servicing (for example, mobile phone-based enrollments in RED). All the tasks that were envisaged for the TPA (in case of health insurance) could be taken over by the aggregator federation. This will free-up some cost on the supply side which can be utilized to reduce the premium, or to do prevention-promotion activities.

Use of mobile phones for enrollment has reduced policy issuance time. Under the manual process used by BAGI, insurance cards used to take 30 days to reach the customers. With mobile phone-based enrolment, confirmation is received instantly and the cards are available in six days. This is of great comfort to the customers as they receive proof of their enrolment much sooner.

On health care provider behaviour

Health care providers who are new members of the network tend to overcharge patients using the cashless facility. Though envisaged as a cashless scheme for the beneficiaries, almost 80 per cent of the claims were being paid as reimbursements, even at network hospitals. Patients were offered “loans” by the federations to help them make payments to the hospitals that could be paid back when reimbursed by the insurer. One reason for the lack of cashless claims was that when patients informed hospitals that they were covered under an insurance scheme, the rates they were offered were different from the ones when they paid cash. It is possible that hospitals that were new members of the network were unsure of the time it would take to get money from the insurer or TPA, and compensated by charging a higher rate to patients. This points to the need to educate hospitals about the process when they are included in the networks.