



Microinsurance Business Models

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THIS ISSUE

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Abbreviations and Acronyms

AIG	American International Group
ASA	Association for Social Advancement
CARD	Center for Agriculture and Rural Development
ICMIF	International Cooperative and Mutual Insurance Federation
ILO	International Labour Organization
MBA	Mutual Benefit Association
MFI	Microfinance institution
MHO	Mutual Health Organization
MMF	Members Mutual Fund
NGO	Nongovernmental organization
RIMANSI	Risk Management Solutions Limited
SEWA	Self Employed Women's Association

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Introduction

Microinsurance is the provision of insurance services for people with low income. A vast majority of the poor in developing countries work in the informal or agricultural

sectors and do not have access to formal insurance.¹ They neither can afford commercial insurance nor access social protection benefits (such as health, disability, or unemployment coverage), which are provided by employers and often co-financed by governments. Of all socioeconomic groups, the poor are most vulnerable to financial shocks but the least protected. They usually cope with financial crises by reducing their household expenditures, drawing on savings, selling productive assets, or taking out emergency loans. Microinsurance is a viable strategy to fill this gap and deliver insurance that is affordable, accessible, and appropriate to the needs of the poor.

Microinsurance is defined as the protection of the poor against specific risks in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. Microinsurance is managed according to insurance principles and funded by

Microinsurance is a subset of insurance that provides financial protection to the poor for certain risks in a way that reflects their cash constraints and coverage requirements.

1. According to the International Labour Organization (ILO) (2001), no more than 20 percent of the active population in many developing countries is included in regular social security systems. In Africa and South Asia, statutory insurance covers only 5 to 10 percent of the working population.

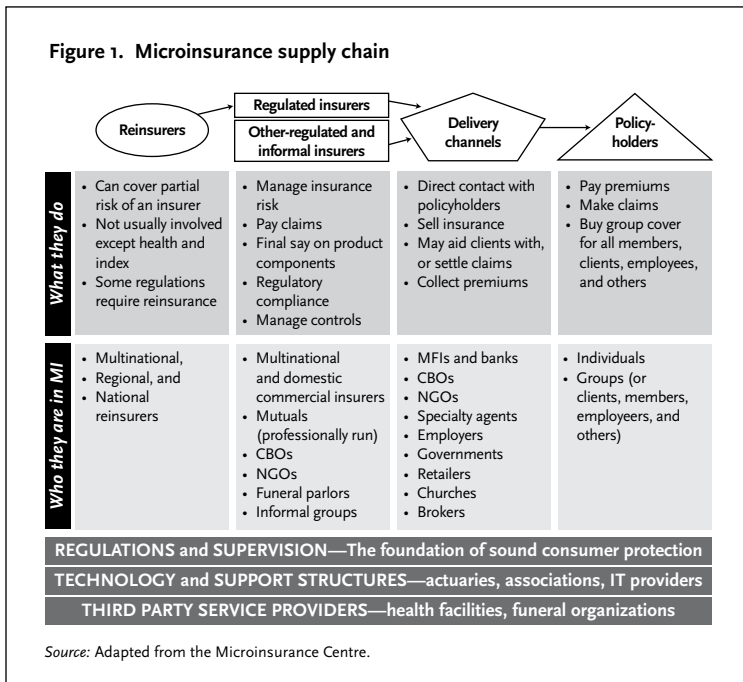
premiums. It can cover any risk that is insurable at a reasonable cost, including illness, accidental injury, death, and property or crop loss. Microinsurance is implemented and distributed through various channels, often associated with the type of insurance. Community-based and mutual insurance schemes now exist side by side with commercial insurers that have started to recognize the potential market among low-income consumers.

This primer reviews the institutional models that offer insurance services to the poor, discussing their organizational characteristics, coverage by region and type of product, and comparative advantages and limitations. Understanding how the different models operate and finding opportunities where they can complement each other is important for scaling up the supply of quality insurance products for the poor.

The Microinsurance Supply Chain

A range of players and institutions are involved in the microinsurance *supply chain* (see figure 1). They include insurance regulators, risk carriers, administrators, delivery channels, technology platforms, and related service providers (such as health facilities or funeral organizations). Insurance *regulators* have a vital role in the sector to protect consumer interests and institute a legal and policy framework for microinsurance. *Risk carriers* (primary insurers and reinsurers) are liable for the risk. They may be for-profit or not-for-profit entities, and they may or may not be regulated by insurance law. Risk carriers include cooperatives or mutual insurance companies, joint-stock companies, public-sector insurers, and a variety of community-based schemes (see Annex III for a classification of risk carrier according to regulation.) *Administrators* offer specialized back-office support or claims processing in the supply chain. The risk carrier or delivery channel also may accomplish these functions. *Delivery channels*, acting as agents, directly interact with low-income policyholders; they include microfinance institutions (MFIs), credit unions, cooperatives, labor unions, retail outlets, nongovernmental organizations (NGOs), post offices, or other specialized sales forces. *Technology platforms* enable the processing of services across the chain and include electronic media, such as personal digital assistants and mobile phones,² or social mechanisms, such as group-based premium collection. *Support institutions*

2. The use of electronic technology is still limited in the microinsurance sector, but it has potential for increasing efficiencies and product quality.



include actuaries, associations, and technology providers. Other critical members of the insurance chain are associated with specific products, including *health care providers* or *funeral organizations*. These entities are third-party facilities that work with risk carriers or independently manage and sell health or funeral insurance.

Microinsurance is a new field that is growing and innovating. Consequently there is limited evaluative evidence on the effectiveness of different business models and their impact on clients. There is ample practical evidence, however, of good and bad practices that contain important lessons.³ Drawing from these experiences, the success of microinsurance is centered on the following factors:

3. The CGAP Working Group on Microinsurance launched a project in 2003 to document the experiences of microinsurance operations around the world and identify good and bad practices. 24 case studies were conducted, documenting the lessons of more than 40 organizations. http://www.microfinancegateway.org/resource_centers/insurance/insurance1/case_studies

- the products must be demand-driven and respond to the needs and abilities of the low-income market
- the products and processes used to deliver insurance must be efficient
- the institutions providing coverage must offer adequate protection to policyholders and manage their risk and long-term solvency

The different institutions involved in microinsurance vary in the degree to which they meet these criteria or experience trade-offs. For example some institutions have a high level of efficiency but may not offer products that consumers truly value. A variety of factors can influence the delivery and effectiveness of insurance, including the ownership structure of the risk carrier, the extent to which policyholders are involved in designing or managing their insurance, the risk-management capacity of the institution, and the degree to which it is regulated.

Regulators and supervisors have an important oversight role to protect consumer interests and help develop the market for microinsurance. *Consumer protection* issues are cross-cutting and seek to ensure that insurance providers have sound governance and management structures and are accountable to clients; risk carriers are able to meet their financial obligations and build solvency over the long term; delivery channels market insurance appropriately; and insurance products are of value, have simple claims processing and dispute-resolution channels, and educate clients about the terms and conditions of the coverage.

Regulators also help to build a *supportive and inclusive policy framework* for microinsurance that allows different types of providers to reach various market segments with products of value (see box 1 for characteristics of an inclusive insurance sector). While regulators are recognizing the need for greater access to insurance for the poor, few countries have implemented regulations for microinsurance. India introduced the first microinsurance regulations in 2005, followed by Brazil (2005), the Philippines (2006), and Peru (2007). South Africa has increased voluntary targets to serve the low-income market through its Financial Sector Charter and is considering introducing a license for funeral insurance that carries reduced entry and compliance requirements.⁴ Regulators commonly face the challenge of balancing access and stability objectives in the insurance market. On one hand they seek to ensure that risk carriers and delivery channels meet the minimum

4. McCord, Weidmaier-Pfister, and Chatterjee (2008).

Box 1. Characteristics of an inclusive insurance sector

Characteristics of an inclusive insurance sector include:

- Access for all insurable people
- Multiple and diverse types of providers
- Financially sound providers and intermediaries
- Access at reasonable cost
- Diversity of products
- Effective consumer protection
- Microinsurance as an integral component of the financial sector

Source: Klein and Wiedmaier-Pfister (2007).

licensing and capital requirements to protect clients and institutions; on the other hand, however, regulators do not want to prohibitively limit entry to the sector and threaten the availability of needed services.

Risk carriers include both primary insurers and reinsurers (whereby primary insurers transfer certain risks to an external insurer). Reinsurance is important to protect clients and institutions from catastrophic and irregular losses. Insurers generally do not seek reinsurance because their risk on simple products does not approach the deductible for reinsurance. For their part, reinsurers generally are reluctant to insure microinsurance providers because of insufficient volumes, lack of management capacity among providers, limited understanding of the risks themselves, and a perception that the market is not viable.⁵ Few reinsurers are involved in the microinsurance sector, though there is increasing interest to find a niche in the market as products become more complex. Reinsurers that are involved in the microinsurance sector include Munich Re with SurAmericana in Colombia, Swiss Re and Paris Re covering weather risk insurance, and Interpolis Re that is reinsuring health coverage. By and large only insurers that are regulated by insurance law are able to access reinsurance facilities.

The following section discusses the types of risk carriers in more detail: commercial insurers, cooperative or mutual insurers, and community-based insurers (including mutual health organizations, funeral societies, NGOs, and informal schemes). It covers the role of delivery channels and administrators in the context of commercial insurers.

5. Garand and Wipf (2006).

Commercial Insurers

Commercial insurers are for-profit entities that are regulated and licensed under insurance law. They traditionally serve middle- and high-end markets but are recognizing the potential opportunities among low-income consumers. Commercial insurers are newcomers to the microinsurance market but provide the largest share of products, covering at least 38 million people in the 100 poorest countries.⁶ For most commercial insurers, the low-income market represents only a small fraction of their portfolio. They are especially interested in diversifying beyond their traditional market in countries that have a growing middle class. For example insurers in Uganda and Bolivia can build brand recognition in low-income markets that have a large growth potential.

By and large commercial insurers have focused on life insurance products that are less risky, easier to manage, and, thus, more likely to generate a profit. Life insurance and accidental death and disability coverage account for 67 percent of insurance products commercial insurers provide.⁷ An alternative tier of commercial insurers that are focused on serving the low-income market also is emerging. These insurers have a double bottom line: they are committed to serving the poor and making a profit. Examples of these institutions include Microcare in Uganda and Cruz Salud in Venezuela. Both of them offer comprehensive health insurance to low-income groups. They typically attract financial investments from donors and are able to cross-subsidize services between different income groups to operate on a viable basis.

A key ingredient in making microinsurance accessible to the poor and profitable for the insurer is to minimize administrative costs. Commercial insurers typically work through intermediary *delivery channels* to enhance their efficiency in serving the low-income market. Partnerships with MFIs, trade unions, retail stores, NGOs, and cell phone networks are increasingly common. By utilizing economies of scale, these delivery channels can reduce premiums charged to customers. Because they have established relationships with clients, delivery channels allow consumers to purchase insurance from organizations or people they trust (see below for characteristics of a good delivery channel). These partnerships can result in win-win outcomes for both partners: they enable commercial insurers to quickly capture a sizable market and they enable MFIs, NGOs, and other channels to offer insurance to their clientele without shouldering the risk of

6. Roth, McCord, and Liber (2007).

7. Ibid.

Box 2. Characteristics of a good delivery channel

A good delivery channel will:

- service regular transactions with low income people,
- offer convenience and good customer service,
- enjoy the trust of their clients,
- have a large volume of customers that are potential policy holders,
- be trustworthy to the insurer,
- have secure and efficient systems to collect and deliver premiums, and
- provide transparent information on the cost of insurance services, coverage, and other performance ratios.

Source: Adapted from McCord and Roth (2006).

managing insurance or meeting regulatory requirements. Some MFIs and NGOs, such as Association for Social Advancement (ASA) in Bangladesh and Self Employed Women's Association (SEWA) in India, have tested both approaches—carrying risk themselves and working with commercial partners—and settled on a partnership with a commercial insurer.

Many delivery channels, such as MFIs and cooperatives, have regular financial transactions with the low-income market and are well positioned to serve as intermediaries. For such financial service providers, credit life insurance is an important tool to protect their own portfolios, and it is often sold on a mandatory basis. These products, however, offer little value to clients. The exception may be group-based loan schemes where credit life insurance can protect group members from shouldering the full cost of a deceased member's loan.

Commercial insurers also partner with *alternative delivery channels*, including retail chains, post-offices, and computer kiosks, to reach a broader clientele. For example in South Africa, Hollard insurance recently partnered with Pep, a retail clothing store that targets the low-income market, to offer off-the-shelf insurance starter packs for funeral, accident, and cell phone coverage (to protect against stolen cell phones). Clients purchase their insurance at any Pep store and receive an insurance card and policy. They also are provided with education leaflets and access to a consumer helpline to be better informed about the exclusions and benefits.

Commercial insurers are making inroads to microinsurance and scaling up access to simple products—largely through partnering with delivery channels. The value of these products to consumers is

questionable, however, with few commercial insurers investing in the complex products, such as health insurance or endowment-based insurance, that clients demand. For instance where health insurance is offered, it usually is restricted to inpatient coverage.⁸ Generally, delivery channels for their part have not stimulated the development of new products to better meet customers' needs. Examples of the few that have include BancoSol in Bolivia, ASA in Bangladesh and SEWA in India. As the market gets more competitive, innovations will emerge in product design, the use of technology to increase efficiencies, and partnerships with alternative delivery channels, ensuring that clients have access to valuable and affordable products.

A few specialized *administrators* also are working in the microinsurance sector. They are commercial brokers that serve as intermediaries between insurance companies and delivery channels to fill gaps around distribution, product quality, and pricing for the low-income market. They work with insurance companies to customize products for the low-income market, support delivery channels (including MFIs, NGOs, and retail networks) in conducting market research and consumer education, and provide back-office administration support to both partners. Examples of brokers that are specialized in the low-income market include the Micro Insurance Agency and Paralife.

Cooperative and Mutual Insurers

Cooperatives and mutual health insurance schemes are member-based organizations regulated under insurance or cooperative law.⁹ They are distinct from joint-stock companies (commercial insurers) in the structure of their ownership. Cooperative or mutual companies are owned by their members or customers rather than by investors. Therefore profits are distributed to members after reserve requirements are fulfilled.

There are two types of cooperative models: one is the *stand-alone mutual company*, which is independent of any network and usually large in scale. It includes the Center for Agriculture and Rural Development Mutual Benefit Association in the Philippines (see Annex I) and the Yasiru Mutual Provident Fund in Sri Lanka. The second model is a *network of financial cooperatives* that provides insurance services to its members by affiliating with an insurance company. Many cooperatives

8. To keep premiums at an affordable level, most microinsurers usually restrict health coverage to high-cost, unpredictable events, such as hospitalization.

9. In some jurisdictions, insurance law is confined to joint stock companies. See International Association of Insurance Supervisors and CGAP Working Group for Microinsurance (2007).

belong to the International Cooperative and Mutual Insurance Federation (ICMIF), which has 200 members in 72 countries and 4 regional associations.¹⁰ The distinction between mutual insurers and cooperatives is their ownership: policyholders own mutual insurers while cooperatives may be owned by members or larger second-tier cooperatives. For example some cooperative may have three tiers of ownership: individual members, regional or national associations, and an apex body that sponsors the insurer and represents member cooperatives. Depending on the jurisdiction, mutual insurers and cooperatives also may differ in how they are regulated. Otherwise they share principles such as democratic control; limited return on equity; continued affiliation of their founding members; promotion of health, safety, and loss prevention to reduce the costs of insurance; and policy influence of the insurance industry.¹¹

Individual cooperatives that belong to larger networks may offer financial services (such as savings and credit associations) or have a non-financial orientation (such as trade unions or farmer associations). In this model the cooperative is the distribution channel for the risk carrier, where the risk carrier is owned by the network and created for the sole purpose of providing insurance services to the network. This point is a key distinction from the commercial model described previously where the risk carrier and delivery channel enter a partnership. This distinction has important implications on the quality of services that members receive. Cooperatives are derived around this basic shape and easily adapted to the context and preferences of their membership. They may vary in their governance structure or the type of distribution channels used. Serviperu in Peru and La Equidad in Colombia, for example, only have a selection of cooperatives represented on the board of the insurance company. Some cooperatives draw on distribution channels that are not cooperative in their structure; for example, La Equidad in Colombia sold insurance through an MFI, the Women's World Forum. Interestingly the MFI subsequently partnered with a commercial insurer that offered greater flexibility in the product.

Most cooperative insurers do not focus on the low-income market, and those that do tend to sell a limited selection of insurance products. Credit life and long-term savings life are the most widely available products. Depending on the capacity of the insurer, some of them provide more complex products, including family income assistance, and health, funeral, and disability insurance. Mutual or cooperative insurers commonly form federations or interalliances to improve

10. International Cooperative and Mutual Insurance Federation (2008).

11. Fischer and Qureshi (2006).

their outreach and sustainability. In doing so they also improve their bargaining power with suppliers and have the potential to offer better products to their members.

A key trademark of the cooperative or mutual model is its ownership by members. This arrangement ensures an alignment of the insurers' incentives with member interests and provides a natural protection to members from discrimination or disputes on claims. The insurance policies typically reflect the needs and preferences of members who have a voice in management and product development. Another important feature of the cooperative model is its captive membership base. This trait allows them to quickly achieve scale and become financially viable. Many networks have more than 1 million members. Cooperative networks offer an excellent source of equity financing for newer insurers and help grow already large networks. Thus there is little need for external subsidies, besides technical assistance. Cooperatives also have the management and know-how to access reinsurance—especially cooperatives that are members of the ICMIF apex network.

While cooperatives and mutual insurers can and do cater to the poor, their membership base tends to be among middle- and even high-income groups that participate in the formal economy. The range of products is limited to credit-related insurance unless they consolidate their membership and technical expertise to support an expanded range of products. While member ownership generally leads to high levels of accountability, poorly governed mutual and cooperative insurers also can experience mismanagement of funds. The participatory and decentralized decision-making can sometimes slow innovation in new activities and product lines.

Community-Based Schemes

A variety of community-based insurance schemes operate around the world, generally falling outside the purview of formal insurance regulation. Laws other than insurance-related ones regulate many community-based institutions. For example health mutuals, or *mutuelle de santé*, in West Africa fall under supervision of a mutual code, funeral societies in South Africa are registered under the societies act,¹² and others, such as trade associations, may be licensed as NGOs. A second category of community-based schemes are informal in nature, such

12. International Association of Insurance Supervisors and CGAP Working Group for Microinsurance (2007).

as funeral parlors and local associations, and operate outside any legal framework (see Annex III).

A key characteristic community-based schemes share is that they are formed at the community level by people who are uninsured and come together for the purpose of pooling their risks. They are not-for-profit and voluntary in nature and generally promote participatory decision-making and group solidarity. The group defines the products community-based schemes offer, and the products reflect their immediate concerns, such as funeral or burial insurance and basic health coverage. Many community-based schemes also provide other services such as savings, advocacy, and health education.

Funeral societies are the most widespread form of community-based insurers. In many countries the rites associated with funerals are expensive, and communities look to funeral societies for both financial and social support to cope with bereavement. In South Africa, for example, FinMark Trust estimates that there are between 80,000 and 100,000 burial societies that serve more than 8 million people. These societies offer a combination of cash and in-kind funeral benefits for their members. Funeral societies may be registered by a specific act (such as the Friendly Societies Act in South Africa) or may function on an informal basis as a funeral parlor or local association.

Community-based mutual insurers are member-based insurance schemes that typically are governed by non-insurance regulations. A model that is widespread in West Africa is the mutual health organization (MHO) that has been pioneered as an approach to extend social protection for the poor. MHOs are an important source of primary health services in a number of West African countries including Senegal, Mali, and Benin. They also operate in East Africa, although they are less prevalent there. These schemes share a decentralized and participatory approach: the members are owners, decision-makers, and policyholders. MHOs have received attention, resources, and technical assistance from donors as they have the potential to ensure self-financing of health care at the community level. Mutual schemes are established for the sole purpose of providing health insurance and go through an institutionalization process that requires dedicated support and capacity building.¹³ For instance the International Labour Organization's (ILO) Strategies and Tools Against Social Exclusion and Poverty Programme and the French NGO Centre International de Développement et de Recherche have been building the capacity of community-based mutual insurers in West Africa.

13. Fonteneau and Galland (2006).

NGOs usually have a core service outside of their insurance practice, for example in enterprise development, health service provision, or advocacy for a particular group or association. Like MHOs, NGOs typically work closely with donors and governments in offering services to the community, and generally professionals rather than members manage them. Unlike mutual insurers, NGOs are not necessarily member owned. This structure may infer some flexibility in their approaches and choices of partnerships. For example VimoSEWA in India is a union of self-employed workers that is registered as an NGO. It started to provide insurance to its members through parastatal insurers, the Life Insurance Corporation and General Insurance Corporation in 1991, transitioned to take on the risk themselves and subsequently partnered with commercial insurers. It currently works through several insurance companies to offer a comprehensive package of insurance products, including life, funeral, and health insurance.

Informal insurers encompass schemes that are outside any legal authority and are varied in size, scope, and service offering. Like other community-based schemes, they are driven on principles of solidarity and are formed in communities that lack formal risk-pooling mechanisms. Like NGOs, informal insurance schemes may have their roots in non-insurance activities, such as a rotating savings group or a local association. While well intentioned and able to offer a limited scope of insurance services, informal insurers generally do not have adequate expertise to manage their risks over time and protect policyholders. Often these informal groups are primarily social in nature like the funeral societies of Ghana which are critical to the social fabric of the culture, and also provide some “insurance” cover.

In general all community-based schemes tend to be localized and small in scale, drawing membership on a voluntary basis and within a limited geographical area. They tend to target workers in the informal sector, including farmers and the self-employed. A few exceptions exist, such as the Union Technique de la Mutualité Malienne in Mali, which has diversified its membership to workers in the formal sector. A recent estimate based on data from 16 community-based schemes in Africa indicated that on average these schemes have 1,400 members.¹⁴ Besides their small scale, community-based schemes generally have a homogenous membership. This characteristic leaves them unable to diversify risk adequately across population groups or to cross-subsidize between richer and poorer groups. It also leaves them susceptible to adverse selection.

14. Roth, McCord, and Liber (2007).

Table 1. Classification of microinsurance risk carriers

	<i>Regulation</i>	<i>Structure</i>	<i>Ownership/management</i>	<i>Primary product(s)</i>
Commercial insurers	Regulated by insurance law	Work in partnership with delivery channels to reach policyholders	Joint-stock companies; profits distributed to shareholders	Life insurance and credit insurance; health coverage usually restricted to inpatient care
Cooperatives/mutual insurers	Regulated by insurance law; some mutual insurers fall under cooperative law instead	Some mutual insurers operate as a full-service model; cooperative networks own the insurer, thus managing risk and distribution under one roof	Member-owned institutions; professionally managed	Life insurance and credit insurance
Community-based schemes	Not regulated by insurance law; many schemes fall under non-insurance laws. Informal schemes are entirely unregulated	Full-service model: manages risk and markets products to members	Most community-based organizations are member owned; members, typically volunteers, manage most of them	Funeral insurance; health coverage by MHOs

Other factors that limit the sustainability of community-based schemes relate to the lack of risk-management skills and inability to access reinsurance. The premiums under these schemes are typically set by members of the group rather than actuarial data, and are based on what people are able to pay rather than the cost structure of benefits received. Thus these schemes are vulnerable to covariant risks that affect a whole community at once. Moreover, community-based schemes frequently have insufficient or no reserves at all. With the exception of MHOs that may be regulated under a mutual authority, these schemes largely are unregulated and cannot access commercial reinsurance. In many countries there is no legal framework for community-based schemes. Thus while they fill an important gap in the market, policyholders are not receiving an optimal level of protection and oversight.

Table 1 summarizes the key characteristics of the insurance models. It highlights the degree to which they are regulated, their organizational structure, type of ownership and management, and primary insurance products that are offered.

Conclusion

A variety of institutions can and do serve the poor with insurance products. The challenge is to minimize the trade-offs in each model and ensure that different entities are able to offer services that are customized for diverse poor populations. This goal entails building the capacity of community-based organizations and affording them greater technical support and regulatory oversight. It also means working with commercial and cooperative insurers to tailor products for the poor rather than downscale their existing services. An ideal microinsurance market includes different models that collectively meet the demand of different population segments, offering high-value insurance products at appropriate price points.

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Annex I: Case Study—CARD MBA, Philippines*

The Center for Agriculture and Rural Development (CARD) Mutual Benefit Association (MBA) in the Philippines has undergone a fascinating growth process that provides important lessons for the development of the sector. CARD MBA is part of a network of CARD Mutually Reinforcing Institutions (MRI) that includes CARD NGO, CARD Bank, CARD MRI Development Institute, CARD Business Development Services, and CAMIA (a non life insurance agency). More recently, CARD has been instrumental in forming a regional based microinsurance provider, the Risk Management Solutions Limited (RIMANSI) to promote the CARD MBA model in Southeast Asia. Together this network of affiliated institutions offers a combination of core financial services, training, and technical assistance that builds on each other's efficiencies and markets.

CARD MBA has its origins in a non-for-profit NGO, CARD Inc., that was founded in 1986 as a lending institution targeted to low-income women. CARD MBA was formed as a spin-off of the Members Mutual Fund (MMF) originally housed under CARD Inc. The MMF offered pension and life benefits to members linked to its credit products; however, the design of these products was based on member demand and not on actuarial projections, thus resulting in unsustainable plans. In 1999 CARD separated its credit and insurance functions and created an independent insurance company. It professionalized its operations with insurance specialists but retained the member-owned ethos by forming an MBA. The regulatory environment in the Phil-

* Drawn from McCord and Buczkowski (2004).

ippines was supportive of MBAs, with low capital requirements and an easy licensing process. By obtaining an MBA license, CARD was supervised by the Insurance Commission and able to offer protection to its members.

The MBA model has advantages in terms of tax-exemption, focus on member satisfaction, and involvement of members in product development. On the downside, however, the MBA model is limited to its members and cannot offer services to the public at large. The CARD MBA has capitalized on the membership of its partners under the CARD umbrella, particularly the NGO and bank, and thus overcome this limitation. Its insurance products (life insurance, loan redemption insurance, and a long-term savings product) are mandatory, providing scale to the institution and preventing adverse selection. In fact the CARD Bank and NGO act as the distribution channel for 98 percent of the premiums the CARD MBA generates. The relationship with its partners also offers other cost-savings and efficiencies, in terms of shared technologies and training to members. As of December 2007 CARD MBA was insuring over 2.5 million individuals.

The CARD network also has formed a technical-assistance support institution for the microinsurance industry, RIMANSI. It provides fee-for-service technical assistance to MBAs in market research, compliance with regulations, risk management, and product development. RIMANSI builds the capacity of MBAs and facilitates access to reinsurance services. CARD MBA also has supplemented its core insurance products by partnering with the government health insurance scheme, PhilHealth, to distribute health coverage to its members. It recognized the high demand for health financing among its members and saw the opportunity to outsource this product to PhilHealth, which was looking to increase distribution of its products in the informal sector. Interestingly there has been a low uptake of this voluntary product among the CARD membership, likely a function of the product quality and benefit levels.

Annex II: Case Study—TATA AIG Life Insurance Company, India^{**}

The TATA-American International Group (AIG) Life Insurance Company is a joint venture between the TATA group, one of the largest industrial conglomerates in India, and AIG, one of the world's largest insurers. The partnership was established in 2000 following the privatization of the Indian insurance industry. TATA-AIG first entered the low-income market in response to licensing conditions for working in India, but it soon developed a specialized microinsurance unit and an innovative distribution and servicing strategy for reaching the poor.

In 2001 the Insurance Regulatory and Development Authority imposed quotas to compel insurers to sell a minimum percentage of their life insurance policies in specified rural areas, where the penetration of insurance is low and a majority of India's poor live. This regulation created enormous pressure for insurance companies that largely were servicing urban and higher-income segments. Some companies approached the regulation as a cost of doing business and merely down-scaled their existing products (by reducing benefit levels and premiums). Others, such as TATA AIG, saw it as an opportunity to expand their presence in the low-income market. The company created a specialized microinsurance unit whereby the sales, servicing, and administration was consolidated under one division. They understood that the key to reaching the poor was in finding innovative delivery channels. They started to work with a network of microfinance organizations (MFIs) by partnering with a microfinance wholesaler, the

^{**} Drawn from a) Roth and Athreye (2005). Written comments from Vijay Athreye, Director of TATA AIG's Microinsurance division.

Bridge Foundation. They experienced high lapse rates, however, largely related to the difficulty in servicing of long-term insurance products with shorter-term loan financing. TATA-AIG thus decided to pursue alternative distribution channels.

In 2003 TATA-AIG received support from the U.K. Department for International Development to test a partnership using NGOs and community-based sales agents to distribute insurance, and they created a two-tiered structure to outsource their front-office functions to these partners. The micro-agents are individuals or groups who promote, sell, and collect premiums in return for ongoing training and a sales commission. The NGOs supervises and trains the agents, and transfers the premiums and renewals to TATA-AIG. The community-based model has several advantages over working with MFIs: it provides a new livelihood opportunity for poor women and an incentive for them to increase sales (incentives for loan officers can be more challenging to institute), it can draw on a much larger base of NGOs to supervise the agents, it is not limited to the target market of MFIs, and it helps to overcome the difficulty of servicing long tenure microinsurance with credit products. On the downside the model is expensive in terms of training; experiences high transaction costs as individual agents may have to travel to find new clients; and clients cannot benefit from immediate claims payments, an option that may be available when working with MFIs or NGOs.

TATA AIG's microinsurance product line is now managed by a forty five member team within the company, working in partnership with over 250 NGOs and 2500 agents. The products are available in 11 Indian states and have experienced substantial growth in new and renewal premiums. Between April 2007 and March 08 individual microinsurance policies constituted 23 percent of the company's policy count. TATA AIG's microinsurance unit alone has thus exceeded the regulatory mandate of ensuring that 18 percent of its policies qualify as rural, and the company is looking for ways to make the microinsurance initiative run on a sustainable basis.

Annex III: Classification of Risk Carriers By Regulation

<i>Organizations regulated and licensed under the insurance law (insurers)</i>	<i>Organizations regulated or licensed by any other law (formal entities under laws other than the insurance law)</i>	<i>Informal schemes (entirely unregulated and under no legal setting)</i>
<ul style="list-style-type: none"> • Commercial insurers (joint-stock companies) • Cooperatives or mutual insurers (member based) <p>Some jurisdictions exempt certain insurers from being supervised even though they conduct insurance business.</p>	<ul style="list-style-type: none"> • Funeral societies or associations • Cooperatives under the cooperatives authority • Mutuels under the mutual authority or other law • Health insurance schemes or health providers under health authorities • Insurance offered through post offices under the postal authority • Nongovernmental organizations 	<ul style="list-style-type: none"> • Funeral parlors or unregistered death benefit associations • Informal groups and community associations