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VIMOSEWA'S RESURGENCE: INCREASING OUTREACH AND MANAGING COSTS IN A VOLUNTARY STAND-ALONE MICROINSURANCE PROGRAMME

Arman Oza*, Aparna Dalal^ and Jeanna Holtz^

* National Insurance VimoSEWA Cooperative Ltd.
^ ILO's Microinsurance Innovation Facility

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PREFACE

The primary goal of the International Labour Organization (ILO) is to contribute with member States to achieve full and productive employment and decent work for all. The Decent Work Agenda comprises four interrelated areas: respect for fundamental worker's rights and international labour standards, employment promotion, social protection and social dialogue. Broadening the employment and social protection opportunities of poor people through financial markets is an urgent undertaking.

Housed at the ILO's Social Finance Programme, the Microinsurance Innovation Facility seeks to increase the availability of quality insurance for the developing world's low-income families to help them guard against risk and overcome poverty. The Facility, launched in 2008 with the support of a grant from the Bill & Melinda Gates Foundation, supports the Global Employment Agenda implemented by the ILO's Employment Sector.

Research on microinsurance is still at an embryonic stage, with many questions to be asked and options to be tried before solutions on how to protect significant numbers of the world's poor against risk begin to emerge. The Microinsurance Innovation Facility's research programme provides an opportunity to explore the potential and challenges of microinsurance.

The Facility's *Microinsurance Papers* series aims to document and disseminate key learnings from our partners' research activities. More knowledge is definitely needed to tackle key challenges and foster innovation in microinsurance. The *Microinsurance Papers* cover wide range of topics on demand, supply and impact of microinsurance that are relevant for both practitioners and policymakers. The views expressed are the responsibility of the author(s) and do not necessarily represent those of the ILO.

José Manuel Salazar-Xirinachs
Executive Director
Employment Sector

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EXECUTIVE SUMMARY

The relatively slow growth of voluntary microinsurance, as compared to compulsory, subsidized and automatic models, necessitates a closer look at issues of its scalability and financial viability – both at the manufacturing level (insurers) and at the distribution level (intermediaries). All the more so since sustained voluntary purchase of insurance by low-income households is also vital from a social impact standpoint.

After initiating microinsurance in India and gaining useful insights over the last two decades, VimoSEWA started mulling over the question of how (and whether) a voluntary, stand-alone, full-service, multi-product, microinsurance distribution model could be made financially viable. Given the nature of our organization, our tasks were clearly cut out. Consumer education and marketing became imperatives on account of our voluntary character. Being stand-alone meant that we couldn't expect cross-subsidy from other verticals. A full-service model made our operations service intensive (and therefore kept our costs high). Our multi-product nature made our cost-revenue equation for products unbalanced. And lastly, being an intermediary meant that we had to live on fixed and dwindling margins. This threw up many more subtle as well as obvious questions – on ideology, objectives, structure, model, processes and the like. There being no exact parallels globally, we decided to discover answers almost on our own. This is a case study of the resurgence of VimoSEWA into a revamped, focused and cohesive microinsurance programme.

After VimoSEWA became a part of SEWA's Social Security unit in 1999, we witnessed a phenomenal growth in membership, mostly mustered by partnerships with NGOs and microfinance institutions outside the SEWA family. MIcroinsurance was just gaining popularity and VimoSEWA got an "early bird" advantage. Even at that high point, financial viability was a matter of concern but somehow the rising volumes kept our hopes alive. Our jitters worsened as partnerships began to unravel. By 2009 our membership and premium revenue were going down and operating costs and claims persistently exceeded revenues and premiums respectively. This happened even as we seemed to be doing all the right things on social performance. We wanted to retain our social orientation but also wanted to be financially viable and were wondering if both these objectives could really co-exist.

Our size and scale prompted us to address structural issues first. We changed the organizational structure and defined functions with a level of clarity somewhere in between a purely social organization and a typical corporate. A formal performance appraisal system was also introduced. Reducing staff costs and increasing efficiency through performance management was something that had to be pursued.

More fundamental was the issue of the organization's culture. We laid down crisp organizational objectives of growth, efficiency and cost reduction and took steps to ensure that they were reflected in all thought, action and discourse. Individual goals were aligned to organizational objectives, and our focus was shifted from Inputs to outputs. This meant that dispersed efforts were channelled into a common stream of action that invariably contributed to one or more of the organization's objectives. The right culture enables an organization to switch to auto-pilot mode, thus affording more space and time for further growth.

It was essential for us to align our operating revenue (margins) with our acquisition costs. Therefore we had to change our primary performance indicator from membership to premium. We also needed to amend the lopsided compensation structures for our direct sales force as well as our partners, in order to bring acquisition costs under control. Creating win-win situations for the organization as well as the partners was arduous, as expected. In order to achieve a positive gap between margins and acquisition costs, hard selling and soft selling had to be differentiated clearly.

Our product mix was loaded with service-intensive products. We understood that we could afford only a small portion of such products in our sales mix if we wanted to grow beyond a particular scale. To achieve this, we unbundled our products and introduced products that were not service-intensive, such as savings-linked life policies. We also introduced mutual model products into our portfolio as they can offer better flexibility with higher margins. Mutual model products also allowed us to re-position ourselves amidst increasing dominance of government-subsidized social security programmes. Sales contests for our frontline sales force helped boost sales of our slow-moving products and thereby enabled us to retain a balanced mix of partner-agent, full-service and mutual model products.

Having ventured into voluntary microinsurance at a time when it was more considered to be a social protection tool rather a financial service for the poor, we ended up shouldering operational responsibilities that were much beyond the scope of a typical intermediary. Twenty years down the line, an assertive insurance industry, a tighter regulatory environment and risks related to dubious market practices by claimants and providers, as well as our top-line and bottom-line realities, prompted us to re-think our operational philosophy. Our operations had to be lean but more efficient. The costs of investing in processes like cashless claims settlement and in-house software had to be re-assessed in relation to their benefits. We devised a monitoring and evaluation system that culminated in a set of critical indicators that showed how sustainable we were. Although continuing to manage claims sensitively, we began to work towards "zero pendency" instead of "zero rejection".

The impact of all these initiatives has been encouraging. With the right culture settling in there is better cohesion. Premium growth is finally back on the charts and acquisition costs are down, which contributes to fixed costs. A favourable sales mix has enabled us to lower the servicing cost per claim. There has been a substantial saving in staff costs as a result of the revamp of processes and increased efficiency. A viability gap still exists but now we at least know what is and is not possible.

As the regulatory thinking continues to favour a small number of big players on the manufacturing side and a large number of small players at the distribution stage, scaling up beyond a particular geographical area is not going to be possible for an intermediary. At some point VimoSEWA will have to decide whether it wants to continue as an intermediary or join the bigger league of manufacturers. Another option would be a complete disengagement from commercial operations in order to focus on whatever small roles the government schemes offer for grassroots organizations, with other incidental activities like research and evaluation carried out on a not-for-profit basis.
Microinsurance programme management is more about doing several small things rather than taking a major initiative. As we gain clarity on the "what", "why" and "how" of things, links start connecting. Practitioners are always faced with dynamic situations, where decision-making has to take place amid diverse, conflicting and competing circumstances. Organizations that master this art with conviction and resilience attain their objectives sooner or later.

This case study shows how an organization has striven to be socially focused as well as financially viable and how a resilient attitude can spur resurgence.

1 > INTRODUCTION

The last decade has seen significant growth in the microinsurance sector. Development funding by donors and international agencies propagated the concept, and many grassroots organizations took up microinsurance. The global microfinance boom played its role in promoting insurance, albeit as second fiddle to credit. Regulators became more aware of the need to make insurance accessible to low-income persons and promulgated regulations that supported microinsurance.[1] Following this, the mainstream insurance industry responded with innovative products. Some emerging economies are witnessing increasing involvement of governments in this space, with ambitious social security and health coverage schemes being floated. Technological interventions, alternative distribution channels and innovative enrolment and claims processes are enabling cost-efficient scaling up and servicing. Social investors have also started taking an interest in microinsurance ventures. All these developments have benefited the sector in terms of increased outreach, better scope for financial viability and reduced vulnerability of low-income households.

Amidst these developments, three distinct microinsurance models have emerged. The compulsory model emerged out of piggybacking insurance on fast-moving products like microcredit and mobile phones. The active involvement of governments in providing social security in the world's emerging economies has given birth to the subsidized model and public-private partnerships. And third comes the "voluntary" model, which promotes microinsurance through hard selling, much like mainstream insurance, and which currently makes up only only a small proportion of the sector.

All the three models have their strengths and limitations. The compulsory model currently commands a sizeable share of total microinsurance outreach on account of its ability to reach low-income populations in a cost-effective manner, but will stop growing once microcredit markets reach saturation. The subsidized model, on the other hand, will reach out at least to the "ultra-poor" segment as it overcomes implementation problems. But questions concerning the macroeconomic suitability and financing plans of these schemes and their long-term sustainability will remain. The cash sacrifice made by a low-income family buying insurance is real and immediate while the benefits of the product are distant and contingent. This also creates problems for the voluntary microinsurance model, making sales arduous. It also means that the positive impact of insurance on a society becomes apparent only over a period of time, which is possible only if people continue to remain insured for longer periods. Thus the voluntary model by its very nature contains an incentive for organizations to achieve sustained insurance purchase, and may offers better chances of a positive impact on vulnerability. Due to these features, voluntary microinsurance is likely to remain an area of interest in the years to come, notwithstanding its inherent problems of scalability, viability, low demand and potential mis-selling as well as its current inability to build quick volumes. Expanding outreach among low-income populations beyond the captive catchments of compulsory and subsidized models will require perseverance on the part of organizations that that use the voluntary model.

India's huge population, under-served by insurance, its diverse culture and forward-looking insurance industry, as well as its active civil society, have made it a microinsurance laboratory. Many products, models and approaches have been launched, tested and scaled up. Almost all microfinance institutions (MFIs) offer credit life and credit life plus cover. After the crisis in the microfinance sector in 2010, which resulted in repayment difficulties for many MFIs, there has been a renewed interest among MFIs in offering voluntary savings-linked and health insurance products although larger MFIs were already doing so. There is some interest from insurers in developing the "microinsurance agent" model, though that is largely driven by the mandatory Rural and Social Sector Obligations[2]. Market forces are also soon likely to compel insurers to target lower-income populations. The insurance regulator, on its part, has initiated a review of Rural and Social Sector Obligation Regulations, as well as the Microinsurance Regulations, with a view to making them more effective. The recent entrants in the insurance industry have focused on innovative products and, more importantly, processes that enable cost-effective distribution. On the other hand there are some good mutuals offering health and

[1] More detail on the regulatory environment is provided in Section 8 of this case study.
[2] This regulation stipulates that insurers must procure a prescribed minimum quota of business from the rural sector. Please see Section 8 for more information.

simple life cover to low-income households. Subsidized insurance schemes for poor households that were initially launched by certain state governments have now been rolled out at the national level. Involving huge outlay from the state exchequer, these schemes are all set to change the microinsurance industry in India in the years to come. They are based on a public–private partnership model where the risk is carried by the mainstream insurers and a substantial portion of the premium is borne by the Government. Grassroots organizations hardly play any role in this arrangement. On the demand side, high economic growth over the last decade, coupled with expanded poverty-alleviation initiatives, has possibly resulted in the creation of more disposable income in the hands of hitherto underprivileged groups. Though a vast number of people still remains to be covered, a financial literacy movement is gradually making the low-income population more receptive to financial services. During 2011/12, 31.67 per cent of new policies issued by the life insurance industry were in the rural sector and 22.07 per cent of the total lives covered were in the social sector.[3]

In this highly diverse and favourable economic environment in India, certain facets of a robust insurance industry are conspicuously missing. For example, there are no national-level intermediaries working on microinsurance. The mutuals are also more or less confined to particular regions. Similarly, a cooperative insurer, or even a commercial insurer, with an exclusive focus on the low-income segment, is yet to emerge. The thinking at the policy-making and regulatory level seems to be more inclined towards a market with a small number of large players at the manufacturing level (insurers) and a large number of small players at the distribution stage (intermediaries). While the compulsory and subsidized streams of microinsurance seem to have mostly claimed their territory, the voluntary schemes are still dispersed and underdeveloped. How far a sizeable and sustainable microinsurance uptake can be achieved at the bottom of the pyramid in such an environment remains to be seen.

When all is said and done, it cannot be denied that each microinsurance model has demonstrated vibrancy, creativity and resilience in tackling the problem of bringing insurance to poor households.

This case study presents our experience in establishing a voluntary, stand-alone, multi-product, full-service microinsurance distribution model, focusing on the decisions and changes from 2009 onwards. After initiating microinsurance in India and gaining useful insights over the last two decades, we started mulling over the question as to how (and whether) a voluntary, stand-alone, full-service, multi-product microinsurance distribution model can be made financially viable. The case highlights the evolution in products, organizational thinking and culture, and the efforts of a socially motivated organization, to balance client value and economic viability. The authors hope that understanding the decision-making process undertaken by VimoSEWA will help other social organizations trying to be financially viable.

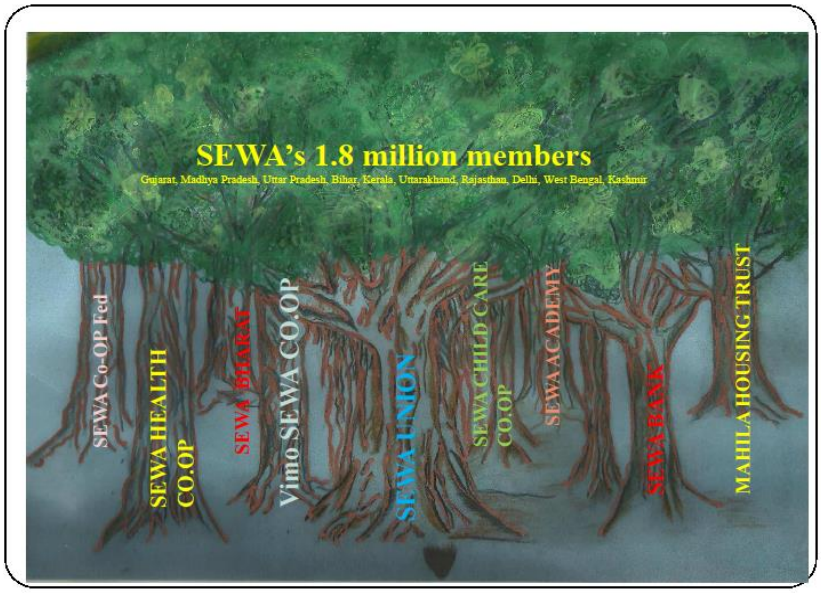
The case study is organized as follows. Section 2 describes the origins of VimoSEWA and the evolution of its products, focusing on two phases: (1) 2005 to 2009, covering the build up to the problems that occurred in 2009; and (2) 2009 onwards, outlining the thought process that guided the changes made between 2009 and 2012. The next four sections discuss these changes: Section 3 details the changes to the organization's structure; Section 4 discusses the cultural shift; Section 5 outlines the new marketing and distribution model; and Section 6 reveals the new product strategy. Section 7 outlines the new operations framework, Section 8 discusses the implications of the changes in the external environment, especially the spread of the government-subsidized health scheme, and Section 9 concludes with key lessons and reflections on VimoSEWA's future.

[3] Insurance Regulatory and Development Authority Annual Report 2011–12.

2 > ABOUT VIMOSEWA

Almost immediately after its formation in 1972, the Self-Employed Women's Association (SEWA), a trade union of 1.8 million women workers from the informal economy, started recognizing the need to cater to the livelihood and financial needs of its members. Founded on the tenets of self-reliance, SEWA soon started promoting programmes and institutions aimed at helping its members, all women, attain work, income and social security. This has resulted in the formation of several trade, service, producers' and consumers' cooperatives. Over the decades, the SEWA family has become a network of trusts and cooperatives. The SEWA family characterizes itself as a banyan tree forest, where the original tree, SEWA, is now virtually indistinguishable from its offshoots which have, like SEWA, grown and flourished (see Figure 1).

Figure 6. SEWA structure



Shri Mahila SEWA Sahakari Bank Ltd. (SEWA Bank) was one of the early ventures set up to offer savings and credit to the unorganized women workers, who at that point in time did not have any access to such services in the formal sector. A study undertaken in early 1980s to analyse the reasons behind credit defaults among SEWA Bank borrowers revealed that quite a few happened because of some catastrophe, such as death or sickness in the family. This pointed to the need for insurance for these women borrowers. The Indian insurance sector, which was at that point a public sector monopoly, was not keen on insuring low-income households as they were considered "bad risks". It was only in 1992 that the public sector life insurer agreed to extend a credit life cover to SEWA Bank borrowers, which led to the birth of VimoSEWA. Soon after sensing success with mandatory credit life cover, VimoSEWA introduced voluntary life and accident, voluntary asset and voluntary health cover, and extension of cover to the spouse and children of the woman member. By 1999 the Indian insurance industry was set to open to the private sector. Following this development, VimoSEWA was operationally separated from SEWA Bank and made part of SEWA's Social Security team.[4]

After VimoSEWA had become a part of SEWA Social Security, there was a renewed focus on increasing voluntary outreach within SEWA's work areas as well as outside them. Backed by donor funding, VimoSEWA could invest in building technical, operational and administrative capabilities necessary to service the higher volumes. On the external front, the new private sector insurers in the market were keen on gaining experience of the low-income market. As a

[4] For more information on the history of VimoSEWA, see the VimoSEWA case study published in 2005 by the CGAP Working Group on Microinsurance, available here: http://www.ilo.org/wcmsp5/groups/public/@ed_emp/documents/publication/wcms_122472.pdf

result, VimoSEWA could negotiate favourable products at competitive prices and highly flexible underwriting and claims processes. All this augured very well, not just in terms of expansion of the programme but also in creating good value for VimoSEWA's customers.

Nevertheless, the real driving force behind the exponential growth of the programme after 1999 was a strong social ethos, which gave rise to a highly member-centric and service-intensive approach. Moreover, the integration of VimoSEWA into the SEWA Social Security unit resulted in a strong proclivity towards health insurance since the health programme was the strongest part of the Social Security unit's work, through the Lok Swasthya SEWA Health Cooperative. Health risks being more frequent in occurrence, they are obviously more perceptible than other risks from a consumer's viewpoint. This coupled with the favourable internal and external factors mentioned above, contributed substantially to the success of VimoSEWA on the outreach and social performance fronts. However this overshadowed certain critical aspects of a microinsurance organization, like financial viability and adherence to core insurance principles. Permeation of such tendencies into the organizational culture made the cultural shift at a later stage more arduous.

Table 1 summarizes various milestones in VimoSEWA's journey so far.

Table 1. VimoSEWA timeline

Year	Milestone
1992	VimoSEWA commences operations under the aegis of SEWA Bank with mandatory credit life cover for women borrowers of SEWA Bank.
1993	Voluntary coverage for spouse of women borrowers offered.
1994	Health insurance for women members introduced. VimoSEWA carried the risk.
1998	Operations expanded from Ahmedabad to rural districts of Gujarat state through SEWA sister organizations. Asset insurance introduced. VimoSEWA carried the risk.
1999	VimoSEWA made a separate unit under SEWA Social Security.
2000	Health insurance extended to spouse of women members. Expansion of operations to other states in India through SEWA sister organizations.
2001	Membership increases in the aftermath of a major earthquake in Gujarat. Established partner-agent model with formal tie-ups with life and non-life insurers. Teams of aagewans[1] formed for door-to-door selling.
2002	Computerization starts.
2003	Partnerships with organizations outside SEWA family for distribution. Research project for health access commenced.
2004	Concept of family cover introduced with health insurance coverage for children of insured members.
2005	Launch of software for enrolment developed in-house by VimoSEWA.
2006	Prompt reimbursement system introduced for health cover in Ahmedabad City.
2007	Quarterly enrolment campaigns start in Ahmedabad City in place of annual campaign.
2008	Integrated approach with health and childcare units of SEWA Social Security adopted. Monthly enrolment campaigns replace quarterly system. Claims processing computerized, again through in-house software.
2009	VimoSEWA becomes the first women-owned multi-state cooperative in the country. VimoSEWA acknowledged in the MacArthur Foundation Award for effective and creative initiatives. Branches opened in two cities outside the headquarters of VimoSEWA.
2010	Health family floater coverage introduced. Savings-linked life insurance product also introduced. VimoSEWA assists FIDES with its proposed microinsurance venture in Namibia.
2011	Saral Suraksha Yojna (SSY) launched.
2012	Project for assisting voluntary organizations in five African countries supported by Government of India, launched with SEWA sister organizations.

Project for development of savings-linked life insurance product for self-help groups launched.

[1] Women trained to promote insurance at grassroots level.

2.1 RISE AND FALL: ACTIVITIES AND RESULTS 2005–09

Before 2009, VimoSEWA offered three variants of a single bundled product (see Box 1). Membership was the primary performance indicator monitored by VimoSEWA from 2005 to 2009. This focus on membership reflected a noble urge to provide as many low-income households as possible with effective risk management mechanisms. The membership grew phenomenally till 2007, driven by the positive factors highlighted in the previous section, while natural as well as human-made calamities contributed to an increasing awareness of insurance.[5]

Box 1. The idea of bundled products

After starting with a simple credit life product in 1992, VimoSEWA soon realized that the risks faced by poor households were diverse. Having tested stand-alone cover during 1990s, the organization introduced a bundled product covering life, health, accident and assets of the insured member, with standard sums insured, in 2001. While the members received it as a bundled product, at the back end the risks were placed with different life and non-life insurers through group insurance policies. This was the only product offered to members of VimoSEWA's till 2009. The idea was to offer comprehensive protection to insured households against major insurable risks through a single window contracting system.

Partnerships with NGOs and MFIs outside the SEWA family also flourished (see Box 2) and dominated VimoSEWA's membership. Microinsurance as a concept – and especially health microinsurance – was just beginning to gain popularity in India. VimoSEWA got an "early bird" advantage in the market and many external partners showed an interest in distributing its bundled products. Partnerships helped VimoSEWA generate good top-line growth from 2003 to 2007. At its peak in 2005, VimoSEWA had 15 NGO/MFI partners outside the SEWA family.

Box 2. Engineering partnerships to increase outreach

By 2003 the concept of microinsurance was gaining popularity among NGOs and MFIs across India. Many organizations approached VimoSEWA and were impressed with its products and processes. VimoSEWA entered into partnerships with these organizations, under which VimoSEWA would offer its bundled product to the members of the partner organization. Marketing and enrolment would typically be the responsibility of the partner while VimoSEWA would provide claims servicing and capacity-building support. VimoSEWA would also share a part of its distribution margin with partners to enable them cover the costs of enrolment. VimoSEWA's own volumes provided a competitive edge that the partners could not have hoped to negotiate with insurers on their own. In addition, they could not have expected the strong capacity-building support and servicing back-up that they received from VimoSEWA from mainstream insurers at the point.

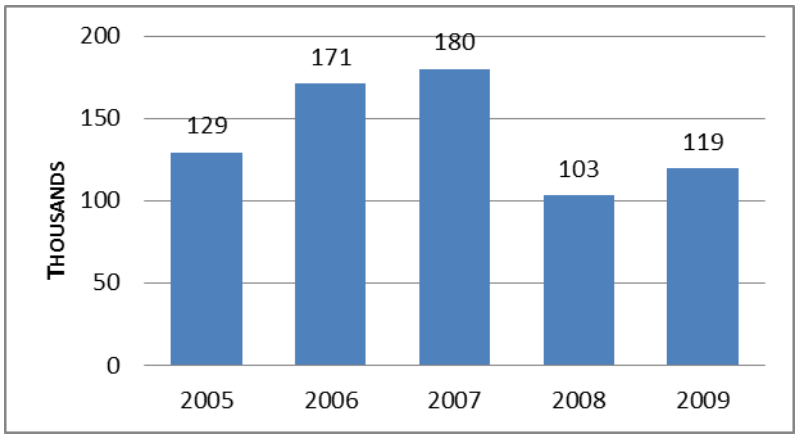
However, the situation started changing in 2007. After two to three years, partnerships began to unravel. Some partners felt they had learned enough about insurance and could now go on on their own. For others the initial interest in health microinsurance withered away, with "bread-and-butter" problems relating to their core business taking centre stage. Even within the SEWA family, the initial draw of VimoSEWA started fading slightly as the programme gradually began to move out of the "project" mode. On the other hand, perennially adverse claims ratios meant that the premium

[5] A severe earthquake in 2001 and riots in 2002 resulted in extensive loss of life and property.

rates could not remain low indefinitely. By this time, insurers had gained sufficient experience of the low-income market and mileage from the SEWA brand. They therefore no longer felt the need to keep subsidizing the portfolio.

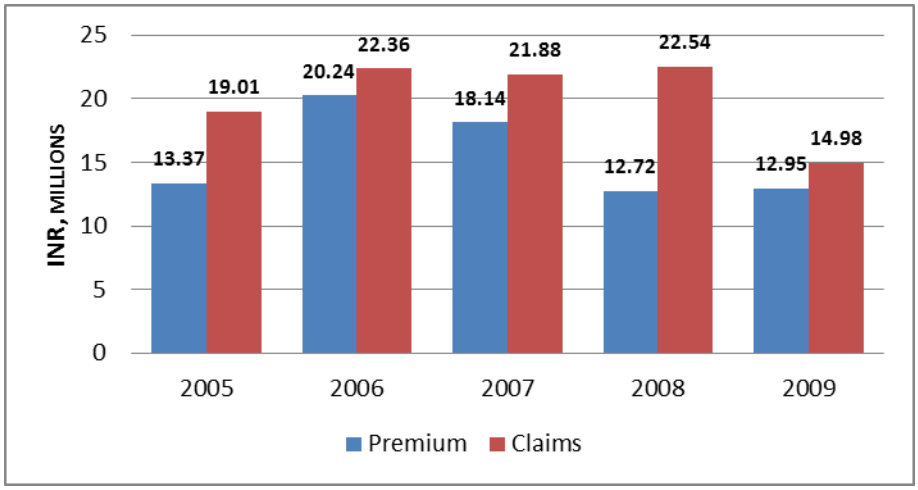
As partnerships ended, the membership in 2009 dropped by just over a third from its peak in 2007 (see Figure 2).

Figure 7. Membership 2005-09



As we started analysing the bottom-line indicators, we noticed there were issues even when the top line was growing. Claims payouts persistently outstripped premiums by significant margins (see Figure 3). While this made the programme socially fulfilling, it also made it vulnerable to premium hikes and any associated drops in membership.

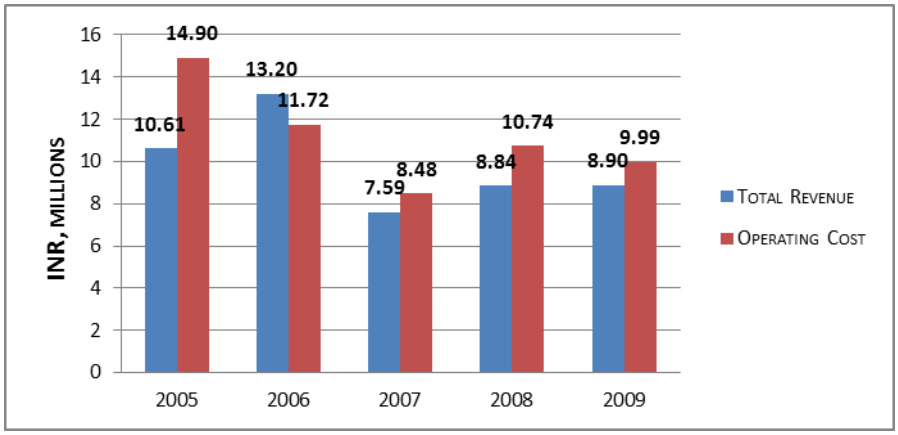
Figure 8. Premiums vs. claims 2005-09



Note: INR = Indian rupees

Insurance rests on the premise of contributions by "many" and benefits to the unfortunate "few". The result of any prolonged disequilibrium between the many and the few is bound to manifest sooner or later. In the initial years, the microinsurance programme may get some "benefit of doubt" from the risk carrier. But eventually the premiums have to attain a level where they can absorb not just the claims payouts but also the distribution and servicing costs. If this does not happen over a period of time, it means there are serious problems with the philosophy, structure, products or processes. Moreover, VimoSEWA, as a microinsurance distribution channel, had to recognize that the distribution margins on their own would never fully cover distribution and servicing costs. Here again, we noticed a persistent trend of costs exceeding revenues (barring just one year) (see Figure 4). Total revenue includes operating revenue (distribution margins), investment income and other revenues (rentals and miscellaneous income). Operating cost includes acquisition, servicing and administration costs.

Figure 9. Revenues vs. costs 2005-09



Upon examining the cost-revenue balance we found that cost-volume-profit (CVP) analysis became extremely complicated in a voluntary distribution model that is wedded to high social performance ambitions (see Box 3).

Box 3. Cost-volume-profit analysis for microinsurance distribution

Cost-volume-profit (CVP) analysis is a topic in managerial economics that enables short-term decision-making on sales mix by establishing relationships between sales volume, variable costs and fixed costs. In our context, the operating revenues consist of commissions from the sale of insurance products received from insurers, expressed as a percentage of the total premium. Our operating costs include costs incurred on acquisition of business, costs incurred on servicing of business and other administration costs. Operating revenues and acquisition costs are variable while servicing costs are semi-variable and administration costs are largely fixed. As we started unbundling our products and introducing new stand-alone products, we needed to understand what kind of products we should sell more of. This made us look at our acquisition cost structures, incentive and servicing mechanisms, and the geographic spread of our operations as each of these elements had an effect on revenues and costs. The critical questions to be addressed were:

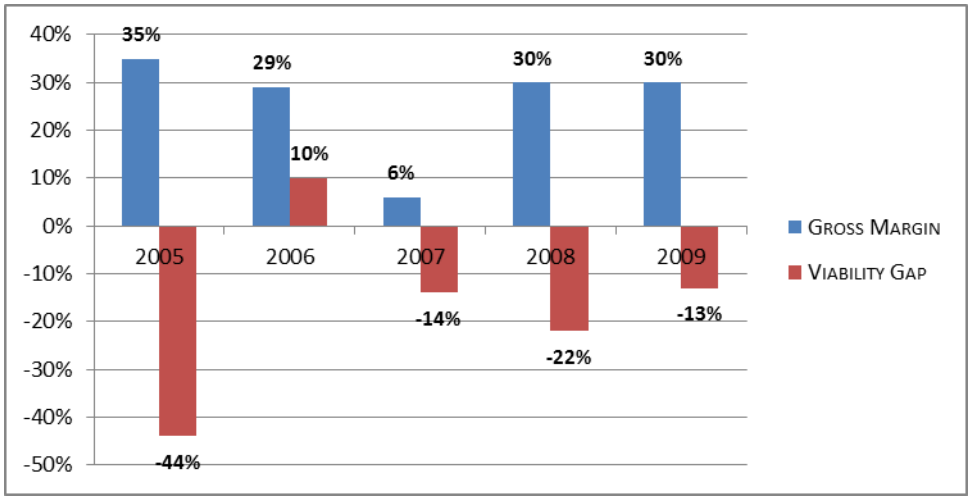
- How much net margin (gross margin minus acquisition cost) can we generate without adding to our fixed cost?
- At what point (volume) can our net margin finance at least a part of our fixed cost (say, the salaries of our marketing team)?
- What could be the sales mix at which we can attain an optimal CVP relationship?
- Beyond which point of volume for each product will our semi-variable cost vary (optimum servicing capacity at current cost)?

The marketing model, product and sales mix strategies and servicing philosophy discussed in this case study have been greatly influenced by this CVP analysis.

A similar enigma was posed by the gross margin versus viability gap trends,[6] which did not reveal any correlation, though both showed an uneven path (see Figure 5). In fact, when margins were higher, viability gap also was higher, suggesting that costs were incurred without regard to revenues. The abrupt decline in margins in 2007 was because we decided not to pass on the premium hike made by the insurer to our members.

[6] Viability gap refers to the excess of operating costs over total revenues, excluding non-cash items like depreciation on assets.

Figure 10. Gross margin vs. viability gap (%)



While costs have to be incurred in anticipation of volumes that bring revenues, they have to be based on proper planning and forecasting. This principle showed us why it was essential to assess the cost-benefit balance before committing to additional costs. It also prompted us to take a hard look at our committed cost structure and evaluate whether the costs incurred were generating appropriate revenues and if not, whether we should continue to incur them (see Box 4).

Box 4. Analysing cost structure

One of the key components of moving towards financial viability is an analysis of the cost structure of the organization. Much more than just identifying ways to cut costs, we wanted to check whether we were deploying costs efficiently. Was the way we spent money contributing to our larger goals of growth and efficiency? This made us analyse our current cost structure and ask ourselves the following questions:

- How far are our acquisition costs being met by our operating revenues and what can be done to optimize acquisition costs?
- How good is our human resource productivity and how can it be improved?
- How efficient are our processes, for example, enrolment and claims servicing? Can we modify them in such a way that costs are reduced but efficiency remains unaffected or can be increased?
- How can we become more sensitive to administration costs such as stationery or printing?
- What kind of skills need to be developed to achieve better prices while negotiating for services like banking, security housekeeping and the like?

We learnt that there was scope for improvement even without compromising on services or efficiency. In fact, we could reduce costs as well as increase efficiency.

Similarly, when incurring additional costs we started asking ourselves the questions "How much will this contribute to our growth and efficiency?", "What are the chances that this initiative will succeed?" and "What if it fails?" As all team members start thinking along these lines, we see a quantum shift in results.

In a tight business model like ours, where margins are thin, ticket size is small and service commitments are often importunate, volumes need to be large. Managing volumes, costs and revenues in an effective as well as socially fulfilling manner can become a gruelling and gargantuan task.

The cost-volume-profit analysis provided useful insights into acquisition costs, sales mix, and servicing structures. Moreover, we also realized the need to develop complementary but regular income streams on the non-operating side, such as rent from unused office space, as well as to invest our own funds as efficiently as possible (see Box 5).

Box 5. Analysing revenues and finding solutions

As it became amply clear that our distribution margins would never be able to cover the entire cost of our operations, we started looking at alternative revenue sources. One of them was non-operating revenue – the revenue that is not directly linked with microinsurance operations. We realized that we had unused floor space that could be rented out. Keeping in view our operations, we had to exercise caution while selecting a tenant but decided to go ahead all the same. We finally found one and today the rentals constitute an important part of our non-core revenue. Similarly we have a fully furnished conference room we only used occasionally. The administration department was encouraged to "market" this to sister organizations and other NGOs/organizations in the city. As this process gains momentum we are seeing good revenues flowing in with an increased occupancy rate of the conference room. It does take a while to "sell" such things internally but once they is picked up on by team members, they start sensing and enjoying the fact that they are also able to contribute to the financial viability of the organization. Small successes when appreciated boost their morale in big ways.

2.2 RESURGENCE: ASSESSING THE SITUATION AND PLANNING TO MOVE ON

Given this situation, at the end of 2009 it was quite an effort for us even to understand what the problem was and where it started. We wanted to grow in a socially responsible and relevant manner and it appeared that we were doing so, but was that sufficient? How much should we worry about financial performance and how much about social performance? What should be our priorities – growth, costs, revenues, efficiency, servicing? Despite a sizeable payback to our customers, why was our membership decreasing? Was something wrong with our operations or was it strategy, or still further, was it our philosophy? These were just a few of many key questions we were confronted with. We had little idea where to start finding the answers.

Our predicament coincided with another important development – the registration of VimoSEWA as the first multi-state, women-owned cooperative in India. The Cooperative has over 6000 individual shareholders and 13 institutional members. It is governed by a Board of Dorectors elected by the general body. SEWA had dreamt of this since the opening up of the insurance sector in 2001. The idea is to instill a mutuality element that can eventually overcome the antagonisms between the buyer and seller, which is a big challenge in insurance. Today, with the benefit of hindsight, we realize that this striking coincidence was perhaps the beacon that offered us some direction in an otherwise murky environment. Now being a cooperative, we had shareholders, who had to be paid dividends sooner or later. Dividends can be paid only out of the profits of the cooperative, which, in turn, is possible only if revenues overtake costs. Still we were not sure where we should begin. We therefore started with an attempt to understand our quintessence, without going into detail. We came up with a short statement that succinctly describes VimoSEWA: "VimoSEWA is a voluntary, stand-alone, multi-product, full-service, microinsurance distribution model." This seemingly generic expression soon proliferated into several vital inferences for us, as shown in table 2. At a pragmatic level, these inferences really defined and confined our dreams, philosophy, strategies, policies, operations and practices for the next three years.

Table 2. VimoSEWA's quintessence – characteristics and implications

CHARACTERISTIC	IMPLICATION
Voluntary	• Hard-selling • Consumer education an imperative • Business acquisition cost
Stand-alone	• No other revenue stream • No scope for integration with other activity
Multi-product	• Products that address wider risk management needs • Managing product and sales mix
Full-service	• All functions in the insurance value chain except carrying risk • Cost of operations
Microinsurance	• Catering to low-income segment only • No cross-subsidy from other market segments
Distribution model	• Heavy reliance on insurers • Limited margins

This small but revealing exercise enabled us to construct a set of broad critical questions, which launched us into our journey after 2009:

- Can a stand-alone intermediary in the microinsurance space ever become financially sustainable?
- If so, at what scale, geographic spread and service intensity?
- How and how much should we balance social and financial performance?
- Where do we need to be smarter and what should be the degree of transparency and accountability?
- How much of our time should be spent on what is right or wrong and how much on what is expedient?
- What is the best we can do?

With these few notions in mind, we started working on a five-year business plan. A business plan often becomes merely a spreadsheet exercise unless it reflects the genuine intentions of the organization and enjoys complete involvement from everybody within it. The business plan was drawn up after a lot of deliberation and brainstorming. Today as we are in the midst of the plan period, many things have changed though many targets are still not achieved. But the conviction and congeniality with which we express ourselves today could not have been possible without this holistic business-planning exercise.

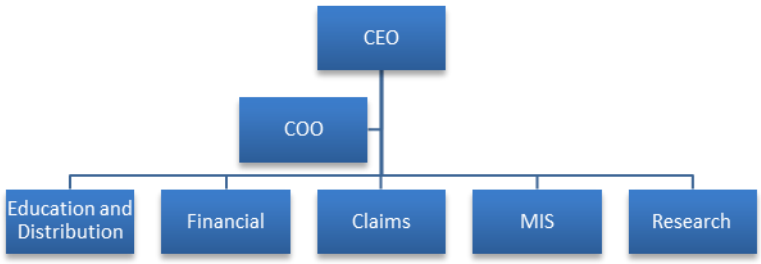
The next sections present and discuss the various changes made to the organizational structure, marketing model, culture, and product strategy between 2009 and 2012. More than the things that we did or the results that we were able to achieve, we believe it is the thought process surrounding the tangible inputs and outputs that is interesting and worthwhile for any social organization trying to be financially viable.

3 > ORGANIZATIONAL STRUCTURE

The fortunes of any organization, and all the more so of an organization engaged in a socially oriented financial service like microinsurance, are largely decided by its human resources. As we started probing into our problems, we realized that a lot needed to be done. At first sight things appeared to be quite smooth. Our staff turnover was quite low, we had a good mix of externally recruited professionals and home-grown talent; like most social organizations we had a flat structure, and the communication levels among the teams also appeared to be quite high. Despite this, some operational processes were not flowing smoothly. Despite everybody feeling they were giving their best, and appearing to be doing so, the outputs (as measured by organizational-level indicators) were not always satisfactory. Social organizations generally do not believe in hierarchies as they sometimes impede creative and inclusive approaches to activities. Even if there is a structure it is not followed strictly, for the same reasons. However the absence of a clear structure sometimes tends to reduce accountability, especially where the activity involves a "buyer-seller" relationship, like insurance. We observed that lack of clear lines of authority and responsibility kept the organizational environment congenial but was thwarting performance and proper alignment of objectives.

We had an organizational chart (see Figure 6) to start with, but it was too dispersed laterally, considering our scale. Moreover, the operational processes were not aligned with the organizational structure. As a result, the process flow criss-crossed the structure, thereby creating confusion and lack of ownership. While we wanted to retain our informal touch, we also had to infuse efficiency and accountability through clearer roles and responsibilities across the organization.

Figure 6. VimoSEWA's organizational chart, 2005



Source: D. Garand: *VimoSEWA, India*, CGAP Working Group on Microinsurance: Good and Bad Practices: Case Study No. 16, Geneva, 2005

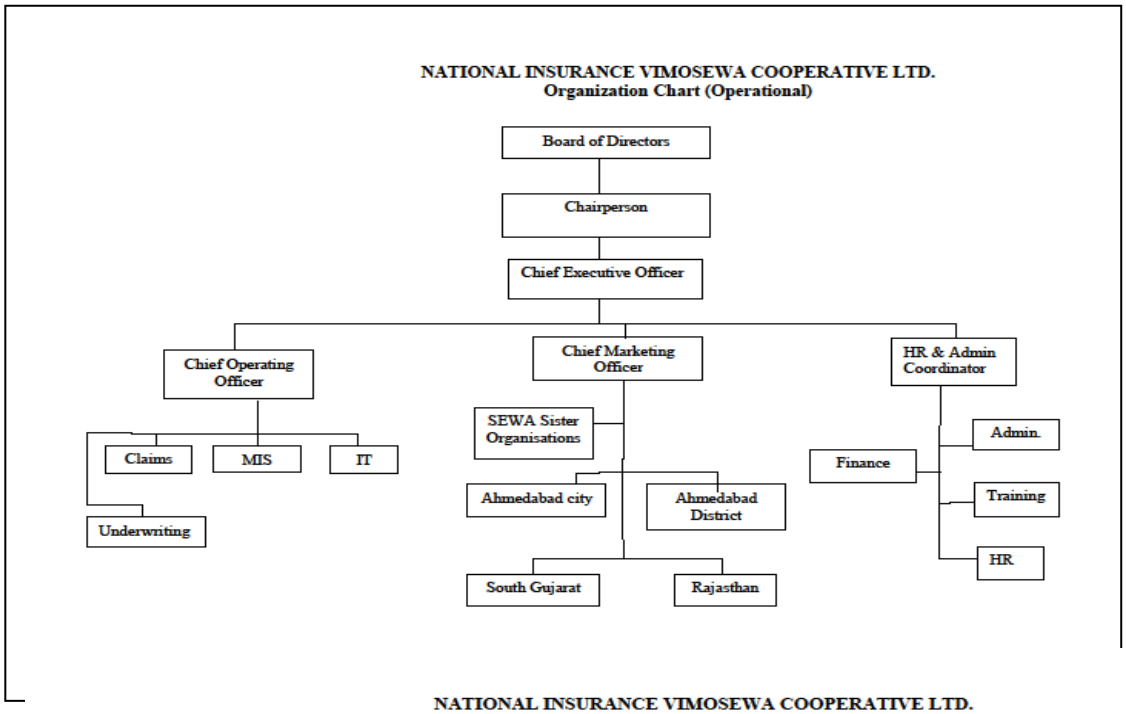
3.1 NEW FUNCTION-BASED ORGANIZATIONAL STRUCTURE

We therefore came up with a structure that was conceived along functional lines (see Figure 7). At the same time our scale did not warrant too much lateral or vertical dispersion. Our new structure included marketing and operations as core functions, and human resources (HR), finance and administration as one non-core function. Typically for a social organization, we had not had a separate marketing function hitherto. We had had a coordinator looking after the sales team, while different people with other operational roles used to look after partnerships. All of them eventually reported to the chief coordinator but this lacked cohesion. Going back to our quintessential voluntary characteristic, with its "hard-selling" implications (table 2, above), we thought that marketing had to be a vital function if we were to grow at a healthy rate. We wanted the marketing team to focus on consumer education, selling strategies, compensation structures for local insurance promoters and developing new distribution channels to attain growth.

A new underwriting function was introduced to ensure accuracy in proposal forms and receipts coming from the field so as to reduce delays and disputes. Underwriting, contracting, data management and claims were all made part of the operations function. The target here was to attain operational efficiency at reduced cost by re-designing and re-aligning operational processes. Reducing claims turn-around time was also made the responsibility of operations. Organizational efficiency could not be achieved without the right alignment of staff. We wanted people to acquire a professional outlook but at the same time retain our social ethos. Voluntary microinsurance as a business model needs high energy levels and determination to serve a "difficult" market segment, which only a strong social ethos can provide.

At the same time, voluntary microinsurance is equally about handling certain challenges of insurance like adverse selection, moral hazard, rejections, dropouts, and operating costs. Most importantly, there was a perennial need to improve products and processes and seek innovations that made social as well as financial sense. We needed policies and practices that promoted better performance and discouraged under-performance at all levels. The capacity-building needs of the professionally trained as well as the home-grown talent had to be assessed and synergy had to be attained between them. All this made us carve out a new HR function. Alongside administration, capacity building and finance, HR was entrusted to a functional head (see Figure 7).

Figure 7. VimoSEWA's organizational chart, 2012



NATIONAL INSURANCE VIMOSEWA COOPERATIVE LTD.
Organization Chart (Operational)
Board of Directors
Chairperson
Chief Executive Officer
Chief Operating Officer
Chief Marketing Officer
HR & Admin Coordinator
Claims
MIS
IT
Underwriting
SEWA Sister Organisations
Ahmedabad city
Ahmedabad District
South Gujarat
Rajasthan
Finance
Admin.
Training
HR

Creatir d to
workin urse
of thei ions
also re ince
the pu and
respon as
confusi (see
Sectior onal
objecti onal
issues,

Vignette 1. Managing administrative costs

Annual services such as housekeeping, security and computer maintenance have significant cost implications. We started looking more closely into the annual contracts for these services, which were hitherto being renewed almost automatically. Well before the contract for a particular service was due to expire, we began to analyse the contract and the performance of the vendor, calling for quotations from other vendors. Negotiating with service providers with full market information makes a difference. It also gives an opportunity to improve the services and contract terms. Monitoring the delivery of contracted services in line with the services offered also enhances efficiency. We realized that such an exercise leaves us with at least some benefits – reduced cost, better terms, some value additions or a more efficient alternative.

VimoSewa's administration team now maintains its own profit and loss account to assess where it stands. Containing costs is not just about frugal consumption; it is also about strategic thinking and deft manoeuvres.

Neelam Christian, HR, Finance & Admin. Coordinator, VimoSEWA

3.2 PERFORMANCE MEASUREMENT

The design and introduction of a formal performance appraisal process was another initiative launched alongside the new organizational structure. Many social organizations tend to be uncomfortable about such "corporate management practices". Often this is because performance measurement is difficult in social organizations. But for an activity like voluntary microinsurance where the top-line as well as bottom-line performance indicators can be well defined, there is no reason to be wary about it. We were convinced that a well-designed performance appraisal system that was clearly aligned to the organizational objectives of attaining growth, efficiency and cost reduction was essential. The idea was to break down the organizational goals, which tend to be broad, to the team and individual levels so that everybody understood exactly what was expected of them and how their work could contribute to the larger organizational goals. In the absence of such a "connect", employees do not see the direction in which they are supposed to move. Once this is clear they also know "how" to move and are thereby able to improve their performance. From the organization's point of view, this exercise was helpful as we could then define the tasks and responsibilities at the individual team-member level.

We created two sets of performance indicators for all team members. The first set comprised general attributes like punctuality and adherence to SEWA's values, while the second set covered the work-related attributes of the team member concerned. All general as well as work-related attributes were related to at least one of the three organizational objectives. Appropriate scale (marks) was assigned to each attribute and at the first stage each team member was supposed to do a self-appraisal, after which the appraisal would be done by the immediate supervisor and a review by the next level. Towards recognition of seniority, all employees got fixed marks for every completed year of service in the organization. The annual salary increment would then be decided after grouping employees into four grades of performance. This again would depend upon the overall percentage increase in the wage bill, decided on the basis of the overall organizational performance.

The very concept of formal performance measurement was relatively new. The change of focus from inputs to outputs also brought resistance and reluctance. It is convenient to harp on efforts and intentions, leaving the rest to fate. We had to come out of this effort-based complacence in order to analyse why our efforts were not getting translated into tangible accomplishments. A lot of explanation and deliberation went on before the enigma could be understood. After the first round of appraisal in 2010, the HR team leader was the most sought-after person in the organization, with people asking several questions not just on processes but also on the ethical and moral basis of the system. The underlying challenge was to convince people that an individual's growth cannot happen in isolation from organizational growth. With every passing year since 2010, the objectivity of the system has been improved. It has helped convey to every team member her role, what she is expected to achieve (wherever possible, in quantitative terms), her individual contribution to the organizational goals, what needs to be done to enhance her performance and how that can be achieved.

Alongside the decisions on organizational structure and performance appraisal, certain other HR initiatives were also taken. We realized the need to promote insurance knowledge among the employees. Apart from the training and capacity-building initiatives, we encouraged employees to undertake further study. This also required an effort on their part. We therefore introduced financial incentives for employees who passed various stages of examinations conducted by a premier insurance education body in India. To enable employees to prepare for the examinations, special coaching classes were arranged. We also streamlined our recruitment process. Job descriptions were made mandatory even when a vacancy arose on account of the resignation of an employee. This forced the functional heads to re-visit the role and the processes so that they could be fine-tuned wherever possible. Describing the profile first made it easier to find a person who suited that profile.

Vignette 2. Inculcating a performance culture

After introducing the formal performance appraisal system, in 2012, we felt the need to elevate or promote good performers to the next level. We thought this was required when some team member attained a particular milestone or had successfully assumed the responsibility of a senior colleague who had left the organization. Like most social organizations we did not have a formal promotion policy but we thought that this kind of recognition would help in reinforcing the performance culture. We therefore allotted A+ ranking to two team members. This was a slight departure from the normal A, B, C, D system. One of them was a marketing coordinator whose team had attained an annual premium of Rs 5 million, which was a milestone. As expected this was greeted with some overt and covert opposition from other members, especially of the same team. People tried to play down an A+ member's achievement, saying "What is the big deal? I would have performed same way if I had such a big team." The reason that another team member got a C ranking was also raised. The real reason, we felt, was that people were so focused on inputs rather than results. It takes a while before people understand that there are limits to which mere "effort" can be rewarded. Ironically, the colleague who was awarded the A+ grading eventually left the organization for personal reasons. We have to learn to live with these realities.

Neelam Christian, HR, Finance & Admin. Coordinator, VimoSEWA

While compartmentalization within the organization was intended to bring in clarity about roles and better synergy, as well as generate healthy internal competition, it had its share of fallout in the initial years, as wide divergence in performance emerged among the teams. This led to instances of friction among various functions, one-upmanship and even passing the buck. These tendencies, however, receded, with the functional heads gaining in maturity and the gradual correction of performance imbalance among the functions. A strong organizational focus on certain performance indicators, coupled with some mentoring, kept such aberrations at bay. Both the relationships among the employees and their relationships with the organization are very intricate. Employees working in social organizations also have their own aspirations for growth and progression. The challenge is to marry these aspirations effectively to the organizational goals through enabling structures and processes.

3.3 RESULTS

The indirect impact of these HR initiatives on the top-line and bottom-line indicators shown elsewhere in this case study (figures 11, 12 and 17) is apparent. More directly, we have managed to make the organization leaner and more cost-efficient. Even as we continue with the policy of not making employees redundant, we have reduced the total workforce (not counting frontline sales staff) from 68 in 2010 to 46 in 2012 (see Figure 8). As a corollary, the annual wage bill dropped by almost 21 per cent during this period (see Figure 9). This was significant from a sustainability point of view as salaries constitute more than 60 per cent of our total operating cost. It happened because we were able to avoid recruiting people to fill vacancies arising in the normal course of events, owing to enhanced performance and the streamlining of roles and processes. On the other hand we have been able to offer an average compounded annual

rise of almost 9.5 per cent in employee remuneration during the last three years. Both the minimum, average,and maximum salary levels have also increased in this period (see Figure 10).

Figure 8. Staff numbers, 2010-13

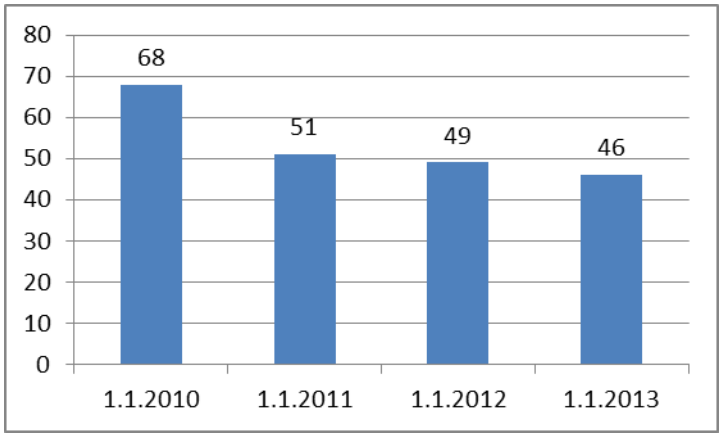


Figure 9. Annual staff costs, 2010-13

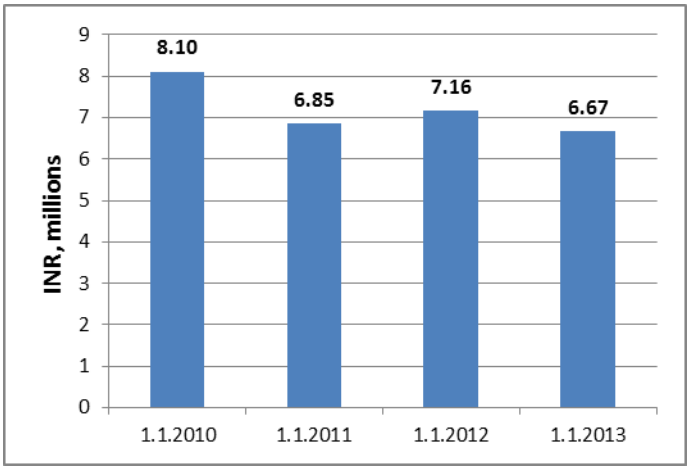
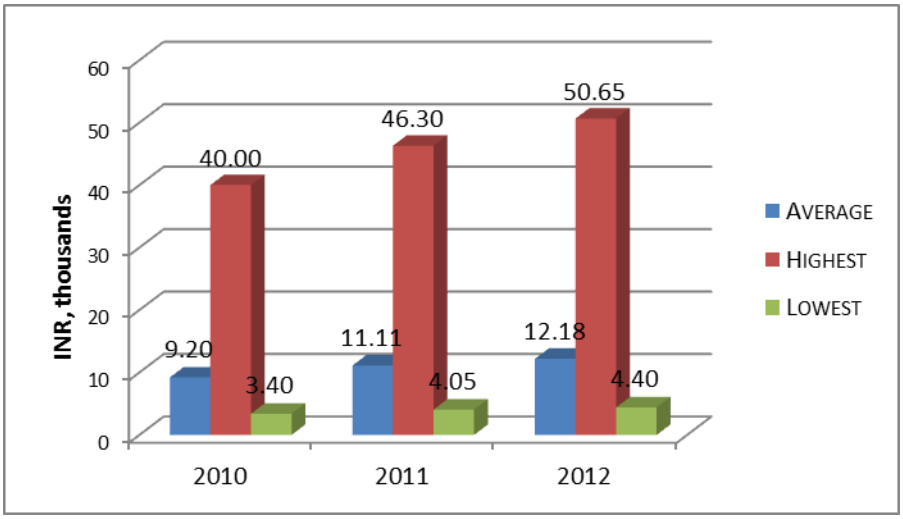


Figure 10. Monthly employee earnings, 2010-12



Performance management is an ongoing and ever-evolving activity. It is neither possible nor advisable to designate a finish line. As we keep gaining insights, we realize that there remains much scope for improvement on our HR front. We intend to integrate some kind of "peer review" into the appraisal system. Employee welfare initiatives like encashment of earned leave and soft loans for specific purposes would boost employee morale and retention. At some point we also want to introduce a job rotation system so that a broadened learning curve can be achieved. At the same time we also realize that skill-building can never be infinite and does approach saturation at some point for every individual. We need to figure out how to handle such a situation.

4 > CULTURAL SHIFT

"Culture is the totality of socially transmitted behavior patterns, … beliefs, attitudes, … and all other products of human work and thought."[7] Organizations have their culture too. The website BusinessDictionary.com provides a useful definition of organizational culture:

> Organizational culture includes an organization's expectations, experiences, philosophy and [the] values that hold it together, and is expressed in its self-image, inner workings, interactions with the outside world, and … expectations. It is based on shared attitudes, beliefs, customs, and written and unwritten rules that have been developed over time and are considered valid.[8]

When we began to review ourselves in 2010, we felt the need to change our entire working style because it was closely related to the old organizational culture. Apart from the structural and operational changes we were implementing, we saw the need to change something more fundamental. Often, what works at the beginning of an organization's existence can become less effective as it grows. As we looked at our vision, objectives, goals, plans, actions and results, we realized we needed to become more rational. We took the following initiatives:

- We defined objectives and goals more clearly – for the organization as well as the teams and individual employees. Any ambiguity here can be misinterpreted. We had to be careful and objective when discussing this topic. Higher growth, more efficiency and lower costs were identified as organizational goals. A placard showing these goals and stating that "everything I do should be contributing to one or more of these objectives" was placed at every workstation as a handy reminder.
- We broke these goals and objectives down into plans and activities that were aligned with them. This alignment should be so apparent that it leaves no room for doubt, ambiguity or misinterpretation. Each function/team should decide how they are going to address the larger organizational goals. Marketing should think primarily about growth; operations about efficiency and cost; administration about non-core revenues and costs; and finance about increasing return on investment, as well as better fund management.
- We noted the need for senior team members to speak one language. Even a slight contradiction will provide scope for convenient confusion. If one member talks only about the need to improve servicing and the other only about high servicing costs, the inconsistency between the two becomes apparent to others. Both of them need to be seen as appreciating the other's perspective while emphasizing their own view.
- Monitoring and evaluation (M&E) systems should reflect the same alignment. The purpose of M&E is to bring out clearly the movement towards organizational goals. We devised an M&E system that went beyond theoretical analysis and culminated in a set of indicators that exhibited our movement (or otherwise) towards growth, efficiency and cost reduction. These included premiums, membership, gross margin, acquisition cost for direct and partnership sales, renewal rate, premium per policy, claims turn-around time, cost per claim, staff costs, core administration cost, and return on investment.
- We consciously shifted our focus from inputs, intentions and sentiments to outputs, results and concreteness. Interactions and discussions on actions and initiatives were to focus on "what was sought" as opposed to "what was intended" and "what was accomplished" as opposed to "what was tried". While we need to keep trying for various things, we also need to understand that if we are not getting anywhere after trying for a while, there is something wrong either with the ends or with the means.
- We took steps to channel dispersed efforts through a conduit of clear organizational, functional and individual goals. Firstly, the organizational structure should ensure that clear and correct communication flows through all the levels. Secondly, systems and processes should be such that all individual action

[7] www.thefreedictionary.com
[8] Vijay Luthra, www.businessdictionary.com

contributes to common goals. For example, if the organizational preference is to maximize the premium per policy sold, sales staff should not be incentivized to increase parameters like membership.

- Most importantly, we decided to make clear operational decisions that truly reflected the stated philosophy of the organization – to ensure that actions, thoughts and discourse were in harmony. We could not be talking of achieving efficiency with acquisition cost on one the hand and paying the same service charge (commission) to a partner whose volumes are persistently going down on the other. Similarly, if the Finance Coordinator follows-up with the CEO on his outstanding travel advance, it should be appreciated as she is just doing her job.

The purpose was to bring in cohesiveness so that all thought and action were directed towards a commonly perceived set of objectives – higher growth, increased efficiency/productivity and lower costs. Instead of looking at each other, everybody should be looking outward together in the same direction. Cultural shift is something that only happens subtly, if at all, over a period of time. It takes a while before the shift starts becoming apparent and gets reflected in the organization's performance. As we started implementing the above initiatives, we witnessed a number of changes. This proved to be the time to identify and promote change leaders. We noticed the following patterns:

- As comfort zones started disintegrating, distractions, stoicism and knee-jerk reactions could be encountered initially, manifesting in different ways.
- As roles were clarified, understanding flourished and people, processes and philosophy started converging.
- As clarity persisted, people started pursuing their tasks more effectively and even started inventing and innovating. Small successes and appreciation motivated them positively.
- Creativity in the desired direction started building up.

Optimism prevails as we continue our task. Management has to use emotions as well as intellect at the right places. For example, we need to be emotional while charging up the marketing team for the attainment of premium targets but we need to be rational while devising the compensation structure for our frontline sales force. We have to be sensitive towards the needs of our target market segment but that doesn't mean we should end up incurring servicing costs that are irrecoverable. If the creative energy and instincts present in every individual can be channelled, organizations can prosper. For this we need to aim at a level where every team member is thinking in her own way though with a correct understanding of the organizational goals. In approaching this goal, certain inflection points have to be negotiated with reason and perseverance. Our experience with this so-called cultural shift has been heartening, especially the way in which people have responded. As the right culture crystallizes, the organization starts moving into "auto-pilot" mode, leaving more space and time for next phases.

5 > MARKETING MODEL

The voluntary aspect of VimoSEWA made marketing or more precisely "hard-selling" an inevitable part of our operations. No matter how strong the need is, insurance does not figure prominently in the priority list even of the educated elite, let alone the semi-literate low-income population. Marketing becomes a necessary evil when it comes to converting latent needs into wholesome demand. "Insurance is always sold, never bought" goes the well-known adage. While most socially oriented organizations are good at things like mobilizing, awareness-creation and training, they face severe challenges when it comes to converting these efforts into sales numbers. VimoSEWA happened to be in the same groove. Insurance at SEWA had been more of a compassionate response to poor people facing risks than an intelligent risk management tool. This being the case, the programme focused more on the eudaemonism offered by insurance than on the economics of it. The presumption was probably that awareness-creation, tailor-made products and personal service would by themselves generate demand.

We realized early on that this situation would prevent us from pursuing quantum top-line growth, which was essential for our larger objective of financial sustainability. The marketing function was thus created to inculcate the much required "sales culture" among the coordinators as well as the aagewans (see Box 6). No matter how good the product and service are, they have to be sold. The National Pension Scheme (NPS)[9] is a classic example of an excellent product failing to generate volumes in absence of a marketing strategy. The aleatory nature of insurance makes it essential for the salesperson to be convincing while dealing with a prospective client. It took a lot of motivation and capacity building of our sales force before we could bring them out of a defensive mindset and instil a sense of confidence in them. This is a big challenge for all social organizations venturing into voluntary financial services.

Vignette 3. Changing face of our clientele

We have seen a gradual but remarkable change in the choices, preferences, taste and perspectives of our members over the years. Earlier the members hardly knew anything about insurance and didn't seem to pick it up even when we tried to explain the concept. They just took our word for granted. Their faith in SEWA was the primary consideration. With the changing socio-economic environment, people have become more aware of the concept of insurance, and of insurance products. We have also started encountering competition from other insurance and other financial products in the market. Members now ask questions about coverage, premiums, long-term benefits, etc. Television has had a definite influence on the way people think. I come across several members who refer to some television advertisement or other for an insurance product and ask us whether we have such products. We now do not have to put in much effort into concept marketing as before. Nowadays it is more about product detailing and comparison with other products in the market.

Ashaben Ajmeri, Aagewan and Board Member, VimoSEWA

Box 6. Direct marketing model at VimoSEWA

Because it is a member-based organization, all commercial as well as non-commercial activities of SEWA have revolved around grassroots-level insurance promoters called "aagewans". They are enterprising women drawn from the community and trained for this particular activity. In the context of VimoSEWA, aagewans constitute the frontline sales force in the direct marketing team. These women, like agents of insurers, go from house to house to promote insurance and enrol members. They use methods like area meetings, personal contact, video displays and claim cheque distribution to promote insurance. They get regular technical and motivational training. Top-performing aagewans are also members of the board of VimoSEWA Cooperative.

[9] NPS is a voluntary pension scheme open to all Indian citizens. NPS Lite, a product variant designed for the low-income segment was introduced in 2009. In the initial years it did not engage intermediaries. After a slack response the system of "aggregators" has been introduced. Details are available on www.pfrda.org.in.

5.1 IMPROVING DIRECT SELLING: TRAINING AND INCENTIVES

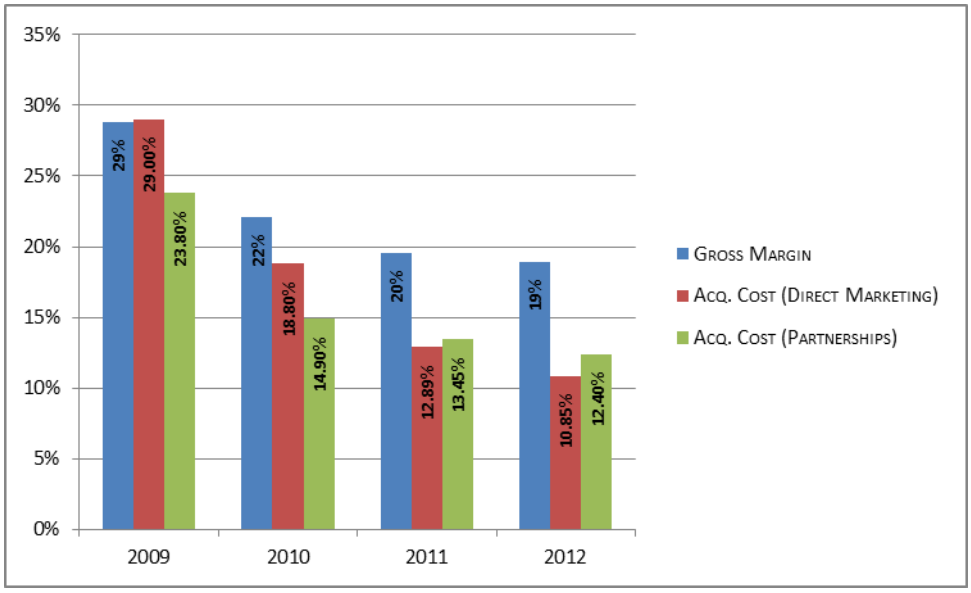
Marketing is much more than mere confidence-building. A sales force will perform only if a progressive incentive mechanism is in place for them. This is the second big challenge we encountered while dealing with our marketing structure. Amidst a persistent drop in premiums and membership in the preceding years, we started dealing with this challenge by changing our primary top-line indicator from membership to premiums (see Box 7). This adjustment was necessary to ensure congruence with the other indicators like gross margins and acquisition cost, which showed how sustainable we were. As distributors, given that we get remunerated on the premium we place with insurers, we cannot be using a different parameter for our salespersons. Top-line focus on membership as opposed to premium had already resulted in an unwieldy proportion of single member policies at the cost of family cover.[10] As a social organization we would have liked to see our membership grow, but we could no longer afford to reduce absolute gross margin and increase our acquisition costs as a result of this. We knew that the emphasis on premiums would dent our membership. But there was no other option. No intermediary can hope to become financially viable without aligning the cost structure (in respect of acquisition costs) to the revenue structure (margins). As we shall discuss in the next section, we tried to address the membership issue through product strategies.

Box 7. Membership vs. premiums

VimoSEWA, being a distribution model, earns its operating revenues from commissions on premiums. The gross margin percentage per product is fixed and does not vary with volumes. The focus on membership ensured that sales for small ticket products were disproportionately high. On the other hand enrolment cost incurred per unit or servicing cost incurred per claim is fixed regardless of the ticket size. Progressive incentives to aagewans on members enrolled resulted in a situation where our acquisition cost exceeded the gross margin. In other words, every unit of incremental sales would increase our loss. To correct this disastrous situation, we had to change our primary performance indicator from membership to premiums. This ensured alignment between gross margin and acquisition cost. Expectedly, this resulted in a drop in membership and an increase in premium. Once we attain a comfortable level of average premium per policy/member, we will address the issue of membership through parallel incentives for new enrolments and maintenance of renewal ratios.

[10] The health insurance product carried options to cover single member, member with spouse or the entire family comprising member, spouse and children.

Figure 11. Gross margin vs. acquisition cost 2009-12



Another major issue to be addressed was the acquisition cost. In 2009, our direct marketing team comprised exclusively of aagewans who received incentives on sales in addition to a fixed monthly honorarium. The dominant fixed component was not correlated to the business brought in by the aagewan, while the small variable component was linked to membership and not premium. The cumulative impact of this incongruence was that our acquisition costs exceeded the gross margins in 2009 (see Figure 11). This meant that with every additional rupee of business our absolute loss would go up. Clearly, we needed a progressive structure that enabled the acquisition cost and gross margin to break even at some stage so that beyond that stage the net margin turned positive and started funding fixed servicing and administration costs. To attain this we had to stipulate thresholds below which even the fixed component would go down and a separate set of thresholds above which the variable component would go up.

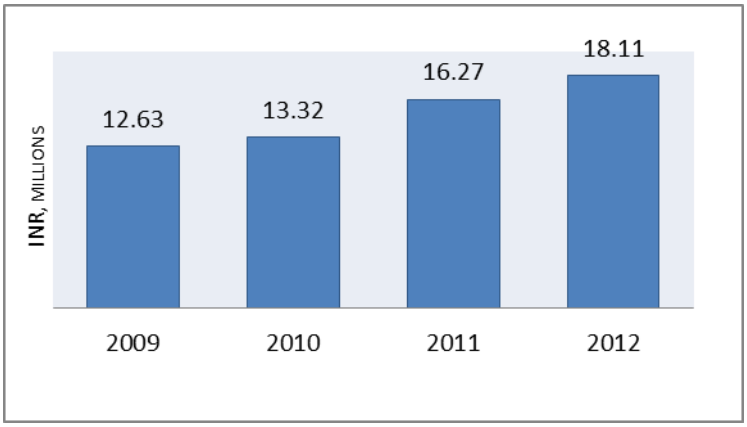
Vignette 4. Changes in the aagewans' remuneration structure

When our remuneration structure was largely fixed, we hardly used to plan our business. We only used to await the next increase in our fixed remuneration. There was also this fear about what would happen once we retired from this work. With the revised incentive structure we can now work out how much premium we will have to generate to reach a given level of remuneration. This has given us better control over our work. As we started getting premium targets we have now started planning our activities and business for longer periods. Earlier we hardly used to look beyond the next month but now we think in terms of the next three to six months. We can earn as much as we want provided we are ready to put in the hard work. With long-term products like Jeevan Madhur, we also now get a renewal incentive. This renewal incentive will serve as a sort of pension for us when we retire. As we increase our business we gain in confidence and try to reach the next milestone. It has all become more and more exciting.

Kamlaben Parmar, Aagewan, VimoSEWA

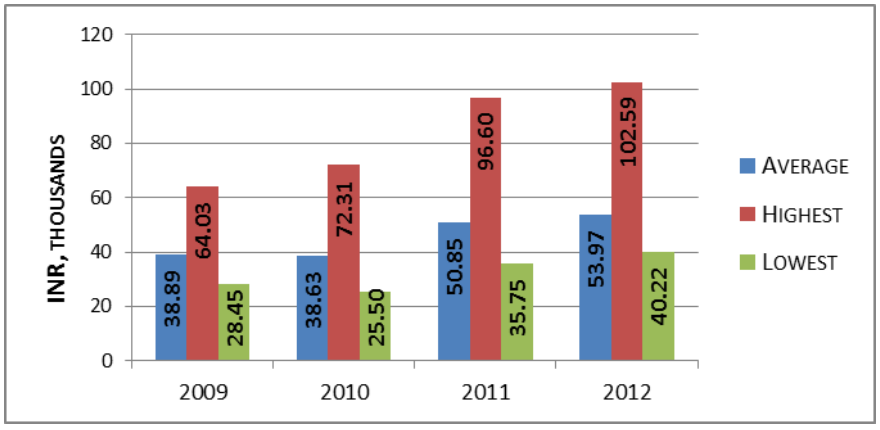
Performance-based remuneration mechanisms, especially for the marketing force, where the performance criteria are fully quantifiable, are based solely on the premise of discriminating between the good and bad performers. It is never easy for a social organization to come to terms with such an unequal treatment of its workers, no matter how much equitable or reasonable the system is. While we were cognizant of the exigencies involved and confident about the equitable character of our initiatives, there was no guarantee of success. The last thing we wanted was a further slippage of premium revenue. Overcoming these dilemmas was never easy.

Figure 12. Gross premium 2009-12



Like many other changes this one also gained a "cautious acceptance" within the organization. Fortunately, the urge to move towards sustainability prevailed and results started showing. Even when our gross margins were going down because of external factors and sales mix adjustments, the sales figures went up (see Figure 12) and the gap between gross margins and acquisition costs entered positive territory (see Figure 11). Importantly, it was indeed fulfilling to see that this also resulted in an upward trend in the minimum, maximum and the average earnings of our aagewans over the last three years (see Figure 13 and Table 3). It was all about creating a win-win situation for the organization and the sales force rather than privileging one at the expense of the other.

Figure 13. Annual earnings – aagewans, 2009-12



In addition to correcting the compensation structure for our aagewans, we also started focusing on recruiting Vimo Saathis – part-time agents who earn a commission on the premium they bring in. Alongside their regular vocation, they can sell insurance and build a complementary income stream for themselves. This is in line with the agency model of mainstream insurers. The volume generated by a Vimo Saathi individually is much lower than that of an aagewan but that is fine with us since they do not come with any fixed wage cost. We can increase their numbers since their acquisition cost never exceeds a certain point, in percentage terms. It is difficult however to find entrepreneurial women keen on selling insurance within the low-income segment. We hope that through persistent recruitment efforts and capacity building we will be able to develop a strong cadre of productive Vimo Saathis. Nevertheless, we have discovered an alternative marketing channel in Vimo Saathis. By the end of 2012 Vimo Saathis surpassed aagewans by contributing 36 per cent of total sales (see Figure 14).

Table 3. Aagewans' fixed remuneration structure (INR)

Monthly honorarium for the current year	Premium achievement for the current year	Monthly honorarium for the next year
2 800	Less than 150 000	No fixed honorarium. Will be converted into Vimo Saathi
2 800	150 001 to 250 000	2 800
2 800	250 001 to 400 000	3 300
2 800	400 001 to 500 000	3 550
2 800	500 001 to 600 000	3 800
2 800	600 001 to 700 000	4 300
2 800	700 001 to 800 000	4 800
2 800	More than 800 000	5 100

Figure 14. Gross premium distribution by sourcing channel, 2012

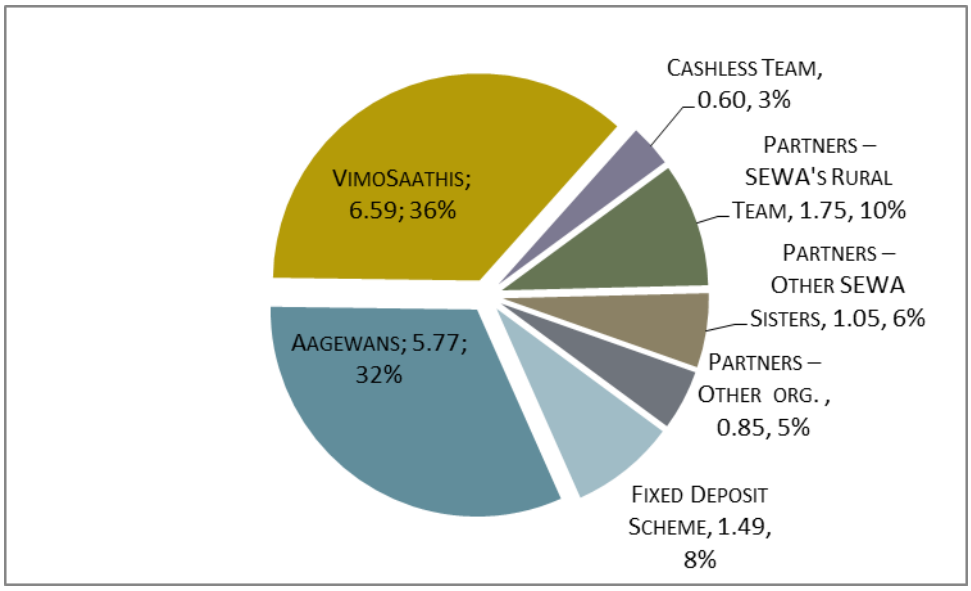
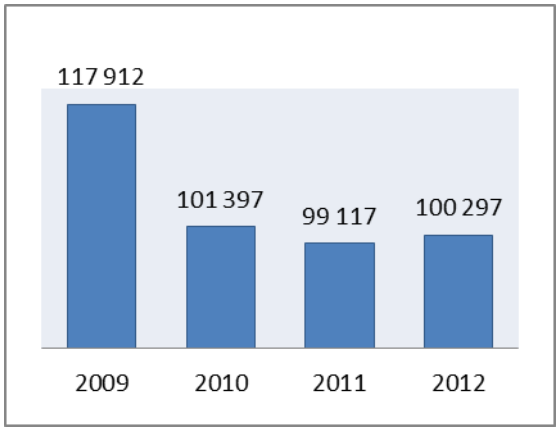


Figure 15. Membership (lives insured) 2009-12



As anticipated, the membership declined initially after first year and has since stagnated (see Figure 15). But now as the marketing model has been by and large set right fundamentally, we expect the membership figures also to go up, backed by our various product interventions.

5.2 IMPROVING PARTNERSHIPS

Partnerships with NGOs and MFIs provided us with ready access to markets and therefore carried a big upside potential. As mentioned earlier, the rise and the subsequent fall in membership and premium between 2005 and 2009 were largely triggered by partnerships. During this period the direct marketing channel contributed quite humbly to the overall volume. While on the one hand we realized the need to increase the share of the direct marketing channel in the overall portfolio to make it less vulnerable to the break up of partnerships, we also wanted to retain the potential growth offered by partnerships. Managing partnerships over a long period requires understanding and camaraderie with partners. Partnerships often collapse when partners no longer see a reason to continue with the programme. For many partners microinsurance is just another "project". In our experience, even after we had invested a lot in helping partners build their capacity, some partners thought this was no longer a "viable" activity. Others felt that they could do it all on their own. We feel that unless partners have a positive attitude to the concept of insurance and an appreciation of its propensity to create social value, the impetus provided by project funding will not take us very far. After this experience our strategy with partnerships is to assess the commitment of the potential partner at the outset and lay down the roles and responsibilities accordingly. As a result, today we have been able to rationalize our acquisition costs for partners, though this has also meant that most of our current partnerships are producing only modest volume. For the partners for whom microinsurance is just another project or a subordinate activity, this was bound to happen. We have reconciled ourselves to it.

Vignette 5. Not just insurance

At our child-care centres we come in touch with parents of children enrolled with us. They often have many issues to share. Earlier we could hardly relate their problems to the need for insurance. But as we grew in our understanding we found it is so obvious. People are concerned about risks like premature death and sudden sickness episodes. They are also concerned about the committed life-cycle events like children's higher education and marriage. They always seek solutions to these problems. As we have gained a holistic view, it has become easier for us to explain the need for insurance. Not just insurance – our effort is to help them in all possible ways. Recently, one of my members received a payout of Rs 10,000 for a serious sickness. Plus, in coordination with our health-care team, we could also get her treated at a much lower cost. This is indeed fulfilling.

Afsariben, Vimo Saathi and Childcare Organizer, Sangini Coopaerative

The lessons are many. Firstly, the model has to be set right no matter how challenging it is likely to be because only then do we stand a chance to be viable. Second, equity and transparency, coupled with the imparting of a broader understanding of organizational goals, do prevail in the end. Third, investments in capacity-building have to be made with a strong emphasis on the CVP relationship and a rigorous performance-driven approach. Fourth, products and services by themselves can never be substituted for marketing. There is no ideal insurance product in this world that would sell on its own. At the same time, for every product there is a customer and for every customer there is a product. And lastly, insurance is as much about building and managing volumes in a cost-effective manner as it is about paying claims. One without the other can render the programme redundant in the long run.

6 > PRODUCT STRATEGY

Being a multi-product microinsurance programme, we could not ignore the implications of our product portfolio for overall growth and profitability. Till 2009 we only offered one bundled product with its three variants.[11] Since the bundled product covered the risks of life, health, accident and assets, the need for other products was hardly felt. A bundled product is ideal from the point of view of the customer as well as that of the insurer. While it offers coverage against multiple risks under a common umbrella to the customer, it also offers the benefits of diversification to the insurer. Multiple risk coverage also allows the salesperson to talk about more things.

6.1 UNBUNDLING PRODUCTS

As indicated earlier, our focus on membership resulted in a portfolio dominated by "individual" policies as opposed to "family" cover. Since the premium for the family product was much higher, the tendency was to sell the much cheaper individual product. But by 2009, this unique selling point started to wither away, with insurers revising premiums upwards based on the claims experience. Moreover the coverage for the health portion under Sukhi Parivar - then our flagship product – was just 2,000 Indian rupees (INR) which was proving to be highly inadequate with burgeoning health-care costs. This gave rise to the need for a stand-alone health insurance product with a decent sum insured (see Appendix for product details).

Since our marketing model could not effectively promote family cover, our net margins also became impaired. Being intermediaries we did not get any direct benefit on account of diversification of risk.[12] At the back end, the risk for this product was carried by different life and non-life insurers and hence the benefits of diversification were not available even to them.

The bundled product, compared with unbundled products in table 4, was posing problems on yet another front. While it was ensuring "automatic" sale of life, health, accident and asset cover in a given pattern, it also was preventing us from exercising any control over our sales mix. A large portion (over 60 per cent) of the premium charged to the client went towards the health cover. With health insurance premiums on the rise, share of health in our total sales was poised to grow automatically. While providing health insurance to the poor is desirable, the fact also remained that as a full-service model, we had to bear the cost of high service intensity for health insurance. Given our sustainability objective, there were limits to which we could afford to service the health insurance portfolio. In addition, there were issues of adverse selection and moral hazard, which got reflected in claims ratios that persistently remained above 100 per cent despite periodic hikes in premium. All this meant that we just could not afford a top-line growth largely dominated by health insurance. We had to ensure that our sales included a sizeable share of products that were not service-intensive, like term life and savings-linked life insurance, which carry a much lower claims incidence[13] and therefore limited servicing costs (see Table 4).

[11] The product was bundled at the consumer's end with life, health, accident and asset insurance in one document. But at the back end the risks for all these types of cover were placed with different life and non-life insurers through group policies. Such a bundling at the distributor's level was necessary because there was no bundled product at the manufacturer's (insurer) level.
[12] The probability of a single risk exposure unit (a life or a family) being affected by multiple risks (death, sickness, accident or asset loss) is very low. Therefore, typically, an insurance policy covering multiple risks is more profitable for the insurer.
[13] Claims incidence is the average number of claims reported for every 100 or 1,000 lives or families insured. Health insurance typically has a much higher incidence than life or asset insurance.

Table 4. Bundled vs. unbundled products

Parameter	Bundled products	Unbundled products
Coverage	Multiple risks	Single risk
Portfolio diversification	Automatic	Manual
Product mix	Limited	Wide
Sales mix	No control	Better control
Client value	Higher	Lower
Product management	Complex	Simple
Product flexibility	Low	High
Distribution channel	Voluntary – retail	Compulsory – bulk
Informal bundling	Not required	Possible

Vignette 6. Moving from bundled to unbundled products

Our bundled product (Sukhi Parivar) cost Rs 175 per year while the stand-alone health family floater product which replaced the bundled product cost Rs 400. Initially our fixation with a small-value product made us believe that our members would never buy such highly priced products. Gradually we started realizing the enhanced benefits of the new product. Apart from a higher sum insured, it also offered members the liberty of getting admitted to a hospital of their choice. In the bundled product the member could get a payout only if she went to specified hospitals, which were mainly government and not-for-profit hospitals. The preference of our members has changed. They seek treatment from good private hospitals. We reluctantly started selling the family floater product but as we started enrolling members, our confidence started building. Adapting ourselves to the changing needs and realities of our members is the best option.

Ashaben Ajmeri, Aagewan and Board Member, VimoSEWA

We introduced bundled products at a time when these were not well known and yet, when the world started talking about them, we had decided to unbundle our products. Curious are the ways of this world. We decided to phase out bundled products and introduce stand-alone life and health products. We started with a health family floater product so as to preclude the possibility of anti-selection within the family. On the life side, we introduced an individual low-cost term life product. We also introduced a savings-linked life insurance product for the first time, realizing that there was a specific segment within the low-income market that could be targeted: typically, it is the households who have some disposable funds to be invested in a savings instrument. Savings-linked life insurance products are appropriate to fund set life-cycle events like children's higher education or marriage. The broadening of the product range, apart from providing choice to members, also offered choice to our aagewans and Vimo Saathis. We noticed distinctly varying patterns among them, with some selling more pure insurance products like health and term life, while others sold more savings-linked life products. The unbundled product regime also gives us the opportunity to correct our sales mix by promoting slow-moving products through incentives and contests (see Box 8) and thereby attaining and retaining a balanced portfolio.

Box 8. Sales contests

Sales contests for distributors/agents are an integral part of any marketing strategy. Typically a contest is aimed at boosting the sales of a particular product or product line in the short term. VimoSEWA started using this tool around

2009 with the same thinking. Contests are for a particular month or two months and are offered over and above the normal commissions or incentives available to aagewans and Vimo Saathis. Contest parameters and gifts are fixed in such a manner that the low as well as high performers find it worth pursuing. Care is taken to ensure that the cost burden of contests do not exceed an acceptable level of acquisition cost. We have succeeded in livening up the sales environment as a result of these contests. A sample contest announcement is given below.

Sales contest for the month of September 2012
Product: Saral Suraksha Yojna. Open to all aagewans and vimo saathis

Policies sold	Gift item	Value (INR)
11	Crockery items	100
15	Bed sheet	125
21	Ladies' purse	215
25	Wristwatch	260
30	Wall clock	375
35	Cooker	435
40	Utensils	580
51	Stainless steel water jug and two tumblers	850
60	Gift voucher	1 100

6.2 ADAPTING PRODUCT STRATEGY

In 2008, India's union government rolled out Rashtriya Swasthya Bima Yojna (RSBY), a heavily subsidized family health insurance scheme for the ultra-poor population. At the conception stage of RSBY, various micro-health insurance schemes were consulted about their experience, especially VimoSEWA. By 2011, RSBY had covered a considerable portion of the country and talks were already being held about extending it to households who were not ultra-poor. This gesture, welcome from a social protection point of view, contained a veiled threat to voluntary microinsurance programmes like VimoSEWA. This development provided us with yet another strong reason to re-position ourselves, as there was no point in competing with a subsidized health insurance scheme. Like any other publicly-funded social scheme, RSBY was fraught with implementation issues but that hardly changed the impending reality. We started applying our minds to how this changed situation could be converted into an opportunity. The answer we settled on was by means of a self-insured hospital cash cover that could be sold as an add-on to RSBY beneficiaries.

The Saral Suraksha Yojna (SSY), which offered a fixed daily allowance for every day of hospitalization, regardless of the treatment costs incurred, was positioned as "wage loss" cover, which RSBY did not offer. The price of the product was based on average hospital stays, details of which were provided by our rich claims data, which were then vetted by an actuary. The product was simple (saral in Gujarati means simple), with very little documentation required in the event of a claim. Since it was a self-insured product, we could draw on our long years of experience with the low-income market to design it optimally. More importantly it offered us a chance to test our risk management capabilities, which in turn could give us access to the additional manufacturer's margin we were so desperately looking for. It also gave us an opportunity to promote the concept of mutuality by passing on the profits that the scheme might generate in future to the policyholders. With hardly any possibility of a catastrophic loss (due to the limit of 15 days of hospitalization per family per year), we could safely carry the risk by putting aside some capital from our own fund. On the flip side, we had to restrict this product to SEWA members only, for regulatory reasons, and thus could not sell it as freely as a partner-agent model product. We managed to sell about 2,000 policies by the end of 2012, which is by no means a decent volume. Initiatives like these always take some time to pick up, but like all other initiatives we hope that this one also will eventually have positive social as well as financial impact. Presently, if nothing else, we at least have a solution to the challenge presented by RSBY.

Our short experience with mutual model products has given us some strong guidance on the way forward for VimoSEWA. Our product strategy is now crystallizing around the three distinct models we have been pursuing (see Table 5). Partner-agent model products are generic, standard insurance products that are generally fast-moving but offer low distribution margins. They are less complex and low in service intensity, but also offer very little exclusivity. Full-service model products offer good distribution margins and are in demand, and thus offer good potential volumes, but are costly to service. Being complex in nature they are prone to dissonance.14 Aimed at striking a balance between the other two models, mutual products offer good margins if managed efficiently,15 can generate good volumes if designed to complement mainstream or subsidized products, and carry the potential to offer good client value because of the mutuality factor. Thus, each model offers varying levels of comfort and challenges in terms of margins, product complexity, demand, potential volumes and servicing burden. All these parameters have significant implications for our objectives of growth, efficiency and cost reduction and hence make it essential for us to navigate smartly between the three categories.

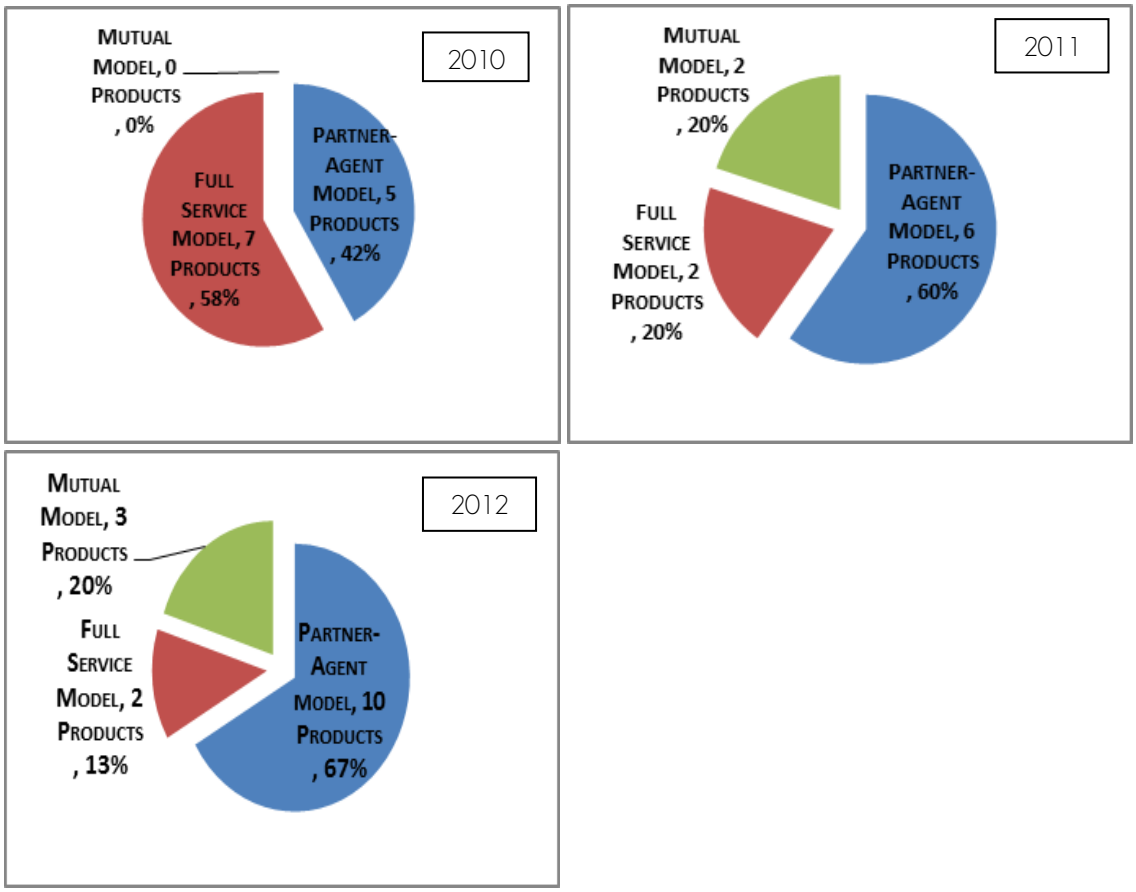
Table 5. Three models in microinsurance

	PARTNER-AGENT MODEL	FULL-SERVICE MODEL	MUTUAL MODEL
Definition	Distributor carries "ready-made" products offered by insurers	Distributors get "customized" products from risk carriers and undertake a large part of claims servicing.	Distributors themselves carry the risk and servicing burden
Margins	Low	Medium / High	High
Product Complexity	Low	High	Medium
Demand	High	High	Medium
Volumes	High	Medium	Medium
Servicing cost	Low	High	Medium
Current products	Sukhi Jeevan, Jeevan Madhur, Credit Life, My Jeevika	Swastha Parivar	Saral Suraksha Yojna, Sukhi Parivar

[14] Cognitive dissonance is "a state of psychological tension arising from incompatibility among a person's attitudes, behavior, beliefs, and/or knowledge, or when a choice has to be made between equally attractive or repulsive alternatives. One example is 'buyer's remorse', a feeling of guilt associated with doubts about the advisability of a purchase decision that one experiences after making an expensive purchase. Marketers try to manage these doubts with supportive information such as testimonials, money-back guaranties, and after-sales service" (Vijay Luthra, www.businessdictionary.com).

[15] Under a mutual model product, the profits (or losses) generated by the scheme after paying claims and meeting expenses remain with the organization. This is not the case with partner-agent and full-service model products, where profits or losses go to the insurer. The organization gets only a fixed distributor's margin.

Figure 16. Product mix 2010-12[16]



The impact of this product strategy has been a shift from a product mix that was dominated by full-service model health products to a more even balance among the three models (see Figure 16). This gives us a better opportunity to optimize our sales portfolio in a manner that represents our social and financial goals. A similar impact is also visible in the sales mix[17] (see Figure 17). In 2010,
more than 75 per cent of our premium consisted of health insurance (based on the full-service model). This composition would have made it impossible for us to upscale sustainably, given the high servicing cost.[18]

[16] "A range of associated products that yields larger sales revenue when marketed together than if they were marketed individually or in isolation from others" (Vijay Luthra, www.businessdictionary.com). In other words, it is the constitution of our product range.
[17] "Proportion of total sales which each product or product line generates, and which needs to be appropriately balanced to achieve the maximum amount of gross profit" (Vijay Luthra, www.businessdictionary.com).
[18] The cost incurred on servicing claims is higher for health insurance on account of high claims incidence. Moreover the documentation requirements for a typical health insurance product are quite elaborate, which means that the cost of scrutinizing a claim is higher.

Figure 17. Sales mix 2010-12

By the end of 2012 the portfolio had become balanced though work was still in progress. With a sustained emphasis on mutual model and partner-agent model products, we hope to "discover" the optimum sales mix soon. The limitations posed by being a microinsurance intermediary, coupled with external developments like RSBY, have clearly motivated us to change our thinking about one particular class of insurance products: health products. While health risks are critical and therefore more perceptible, the fact remains that there are endemic issues of adverse selection and moral hazard plaguing the market, quite apart from the high servicing costs of health products as well as absence of proper healthcare regulations. These are things which VimoSEWA, as a voluntary microinsurance provider, is not fully equipped to handle at this juncture. Thus, while doing away totally with health insurance is neither the intention nor a possibility, we would certainly like to restrict it to only one part of our portfolio, at least for now. Microinsurance is clearly about much more than just health insurance, and provided we have faith in the underlying precepts of insurance, social good can still be achieved in a sustainable manner through such a pragmatic approach.

7 > OPERATIONS FRAMEWORK

VimoSEWA began with a strong concern for poor people facing risks, and the resolve to help them through customized products and processes. This made a strong service orientation a part of our culture, which resulted in huge investments in areas like data management, product development, capacity building and customer-friendly processes. Apart from the strong urge to serve the low-income segment, these investments were necessitated by mainstream insurers' limited understanding of and lack of interest in the low-income market at that point. When VimoSEWA started in 1992, the word "microinsurance" itself had not been coined. The Indian insurance market was a public sector monopoly which considered the low-income population a "bad risk".

Amidst these odds, venturing into microinsurance entailed careful thought and planning. It was thus obvious that VimoSEWA had to shoulder a host of operational responsibilities that were much beyond the purview of a typical intermediary. Developing in-house software to manage data and supply them to the insurers, developing promotional and contractual material in the local language, undertaking awareness-raising campaigns through street plays and later through video display, providing claims facilitation at the member's doorstep and shouldering the entire claims-processing burden so that claims were paid to the fullest extent with minimum rejections were just some of our activities. Effectively VimoSEWA took up almost every task in the insurance value chain apart from carrying the risk.

Almost 20 years down the line, when we started looking at our operations again, clearly much had changed – internally as well as externally. The insurance industry was much more engaged, newer tools and technologies were available to curtail lengthy processes, awareness of insurance had increased, even among the low-income segment, and risks relating to market practices had also increased. All these factors, coupled with the fact that our top line had already begun to decline, made us to re-think all our operational philosophies. We had to look at every process from both a cost-benefit angle and a risk management angle. For example, we found that after all our investments in developing in-house software, it suffered from serious accuracy and integrity flaws. Moreover, it was designed only for our bundled products and had to be virtually re-written to accommodate the unbundled and savings-linked products. On the other hand, insurers were increasingly ready to share their own software systems with us, which enabled direct data transfer to their servers as well as policy issuance. So there was little sense in continuing to deploy huge resources for IT. If technology is not viewed from a strict cost-benefit angle with due consideration for market positioning, scale and operating model, it can become an expensive luxury. Alongside these measures, we did undertake some small inexpensive initiatives like giving renewal reminders to members on their mobile phones through pre-recorded vernacular messages and providing a toll-free number for clients to make claims, in order to speed up claims processing.[19]

[19] All enrolment documents carry a toll-free number which the members are supposed to call in the event of a claim. The number can be accessed from any landline or cellphone across the country free of cost. The member is supposed to provide enrolment details to the customer care executive, who will register the claim and guide the member on the documentation process.

Vignette 7. Improving the efficiency of administrative processes

Prior to 2008, we used to have only one annual enrolment campaign. Since then, however, we have migrated to monthly campaigns, though even today the December sales campaign has special significance and still brings in more than 30 per cent of our annual business. Operationally this means that we have to enter around 15,000 proposal forms/receipts into our system and make the data ready for submission to various insurers by early January since the policies would commence from 1st January. To deal with this workload, we usually hire temporary data entry operators (job workers). These job workers are generally very raw in computer literacy and we have to train them on our software. A huge number of errors in data entry used to be encountered. Either some names were totally omitted or they were wrongly spelt (the receipts are in the vernacular language but data have to be entered in English). The consequence of such errors is that the insurer will not honour the claim if a name is missing or has been entered wrongly. Realizing that human errors were bound to occur, we had to strengthen the software in order to minimize such eventualities. Based on the error patterns, requisite safeguards were placed in the software. It was made more user-friendly so that any data entry operator could operate it. In 2012 the new version went live and the difference was noticed in the December 2012 enrolment campaign. We saved considerable time reconciling entries and could also hire fewer job workers. We need to constantly keep inventing solutions that increase our operational efficiency and at the same time reduce costs.

Tripti Sethi, Chief Operating Officer, VimoSEWA

7.1 DATA MANAGEMENT

At the same time as we re-examined our operations framework, we reassessed how effectively we were using our data. Being a multi-product, multi-channel and multi-location organization, we have to monitor several things across products, channels and locations (for example, acquisition costs, gross and net margins, servicing costs, fixed costs, non-core revenues, product mix, sales mix, renewal ratios and incurred claims ratios). We do this through a three-tier M&E system. The first tier is a basic M&E report that is generated on a monthly, quarterly and annual basis. This report captures exhaustive information on sales, membership, targets, margins and claims. At the second level, a more focused annual review of critical parameters affecting our viability is done. This review is prepared with respective functional heads and team leaders. Specific action points, targets and responsibilities become part of this review so as to ensure that data is not just analysed "for information". Lastly, a comparative snapshot of ten critical indicators is taken and shared with partners and entire staff. This snapshot finally grades the organizational performance, which then forms the basis of the performance appraisal of team members. In addition to this structured M&E system, we also analyse certain products in terms of claim incidence, claim size and claim ratio. These are then broken down at the level of partner/aagewan to assess the divergent trends and enable corrective action. We have also recently started carrying risk on some products, which requires a more frequent and robust analysis. Management reporting, performance management and control are thus the objectives served by the M&E system.

7.2 CLAIMS MANAGEMENT

Insurance is a business of claims. A claim is the only tangible proof of the concept available to customers. Efficiency of claims settlement therefore assumes paramount importance and has significant implications for growth and renewal rates. Given this and the social ethos underlying VimoSEWA's existence, considerable investment of time and energy went into the administration of claims. Thus, while a typical intermediary would at best only assist the insured in preparing the claim documentation, we chose to maintain a fully-fledged claims department within the organization. The claims department would undertake doorstep facilitation, investigation, getting deficiencies rectified, scrutiny of claims, assessment of amount payable and sending the completed claims file to the insurer for final settlement. We also offered

a prompt claims reimbursement system in selected hospitals[20]. Handling almost 4,000 claims annually, the claims team comprised 20 per cent of our staff in 2010, with a 15 per cent share in the annual wage bill. The private sector insurer that carried the health insurance risk had authorized VimoSEWA to actually "settle" and pay claims on its behalf, making VimoSEWA a miniature insurance company.

Vignette 8. Claims management – Experience and challenges

A claim is a moment of truth for clients. Quite often information on claims can be incomplete, unclear or inconsistent. And this is where making a "fair" decision about the claim becomes challenging. For example, one VimoSEWA client bought a health family floater policy with a sum insured of Rs 25,000 in January 2012. In July 2012 she reportedly suffered a head injury following a fall. The discharge certificate from the hospital noted admission was for three days for treatment of a contused lacerated head wound, with a total claim amount of Rs 9,991. Apart from the suturing of the wound no other procedure was apparently carried out, and no diagnostic procedure like an MRI or CT scan was done. Additionally, routine blood and urine tests did not reveal any abnormality. The claimant verbally revealed that she was kept at the hospital till the evening of the day of the injury and then sent home, with orders for a few days of follow-up care. Thus while the hospital documents reported a three-day inpatient stay, other information did not corroborate this. Absence of diagnostic tests indicated that the attending doctor neither suspected nor attempted to verify a deeper injury to the brain. The member verbally admits that treatment was provided on an outpatient basis. Was this then a fraudulent case of outpatient treatment being presented as a hospitalization case just to make a claim? This is difficult to prove without thorough cooperation from the hospital – something that seldom happens in reality. Despite suspicion of fraud, the claim was paid as the documents clearly certified the same. Such cases are far from sporadic. In order to tackle such situations effectively, health insurance policies nowadays mandate the insured to report a claim within 24 hours of hospitalization. VimoSEWA still follows a comparatively lenient policy of accepting claims reported within 30 days of hospitalization. Tackling moral hazard in a microinsurance programme that is committed to a strong social ethos is indeed challenging.

Tripti Sethi, Chief Operating Officer, VimoSEWA

Having the authority to settle claims gave us the opportunity to make that our unique selling point and showcase it to our members and other stakeholders. The policy conditions offered to us then were also highly favourable and flexible. With health insurance constituting a large portion of our total portfolio, claims as a subject assumed precedence over the rest of our activities. While this helped create a good reputation for us, it did not translate into incremental membership or premium, which kept claim ratios highly unfavourable. The good faith on which the whole claims philosophy was based and according to which claims were administered did not translate into sufficient accretion in volumes, making the portfolio vulnerable to adverse selection. Voluntary health insurance is a strange game. While the long list of disease-related exclusions and conditions may look bizarre, without them there is every chance that the insurer will end up with a messy claims ratio. If your claims servicing is bad, business is most likely to be adversely affected, but if the servicing is good there is no guarantee that by this very fact, business will increase.

Another problem with perennially high claim ratios is that the matter does not end with an increase in premium rates, rather it starts from there – a lesson VimoSEWA learned the hard way. Solutions to curb rising claim ratios are elusive. When the premium is raised following a high claims ratio, low-risk members (bookworms) will start dropping out from the insured population as they will find the product uneconomical. However the high-risk members (skateboarders) will still

[20] Though not strict a cashless claims settlement system, the prompt reimbursement system would ensure that the insured gets almost the full amount spent at the hospital before she gets discharged. This was done through a dedicated team of organizers who were allotted specific hospitals. Any member getting admitted to an empanelled hospital would call the concerned organizer who would then collect necessary documents from the hospital and ensure payment while the member is still undergoing treatment.

find the product economical and therefore will continue being insured. This will worsen the claims ratio despite the premium hike, and the portfolio will get caught in a spiral of rising claim ratio and rising premiums. As the proportion of skateboarders in the insured population keeps increasing, the product will eventually have to be withdrawn from the market. Thus, adverse selection limits the insurability of risk for consumers with low expected losses[21] and penalizes them unjustly. Identifying skateboarders before they get insured is difficult as well as expensive. The seemingly bizarre exclusions in insurance policies are primarily meant to keep out skateboarders.

By the end of 2009, our "friendly" insurer had opted out, leaving us with a public sector insurer who would not relax standard exclusions and conditions beyond a certain point, would not delegate claim settlement authority to us, and largely went by the book in settling claims. This was also the time we were migrating from a bundled product with lower health coverage to a stand-alone health family floater policy with a much higher sum insured. The transition to this less accommodating environment was quite painful. Comprehending and interpreting the exclusions and conditions and conveying them correctly and clearly to the members and sales staff was a challenge. A lot of brainstorming and training had to be undertaken, and contracting documents (receipts) had to be modified and the wording made simple but accurate. On the other hand, our new insurer also hardly had any experience of this kind of portfolio. Therefore considerable time had to be spent with them explaining the ground-level situation as far as claims handling was concerned. The claims disposal flow also got disturbed periodically because of various operational reasons at the insurer's end. By 2012, normalcy had resumed, with almost full clarity at all levels on what was and was not possible. Claims ratios for health insurance, however, remained in the red.

Vignette 9. Working with insurers

As microinsurance intermediaries we are delicately poised between the insurer and the members. A judicious approach is needed in order to balance often conflicting interests. To illustrate, an insured member from Khodi village in Ahmedabad district insured her family by buying our Swastha Parivar (health family floater) product for a sum insured of Rs 10,000 in December 2010. She renewed her insurance in December 2011 but forgot to include her spouse in the policy. As often happens, her husband contracted acute gastroenteritis in January 2012 and had to be admitted to a hospital for three days and ended up spending Rs 3,287. The insurer rejected his claim since his name did not appear along with his spouse's for the policy period under which the hospitalization took place. While this was an inadvertent omission, the insurer was technically correct. How can a claim be paid for a claimant who is not enrolled? Realizing the situation, we presented to the insurer the client's previous policy, in which her husband's name was mentioned. We also pointed out that no claim had been reported for any of the family members to date. Being a family floater policy, the premium also would remain the same regardless of the number of family members included (up to a limit of six) and hence there was no question of recovering the premium after a claim had taken place. Based on the above contentions, the insurer agreed to include the name of the policyholder's husband on the policy and pay the claim.

Tripti Sethi, Chief Operating Officer, VimoSEWA

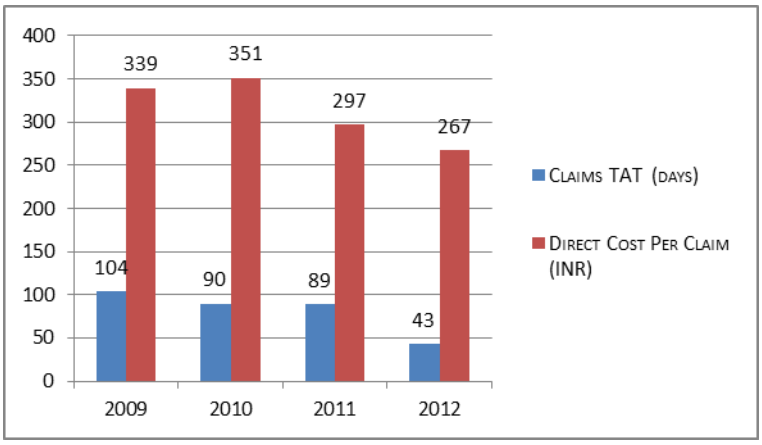
What then was the "ideal" role for the claims function? The mindset acquired as a result of being extremely "claimant friendly" in good faith was subtly preventing us from engaging fully with the harsh realities of voluntary insurance. As we delved further into these issues, we realized that a claim was an event that manifested adverse selection and moral hazard in apparent as well as obscure ways. And therefore while being sensitive to the hardships faced by the low-income claimants, we also needed to be sensible about dubious market practices by claimants and health providers alike. We needed to be accommodating but impartial, compassionate but judicious, fair but smart. This was a really tough balance to achieve.

[21] S.E. Harrington and G.R. Niehaus: *Risk Management and Insurance*, Tata McGraw Hill Publishing Co. Ltd. 2004 edition, reprint 2007 ISBN 0-07-059499-6, p. 186.

Reminding ourselves of our quintessence again, we realized that a perennially adverse claims ratio, apart from violating the fundamental principles of insurance, was also a threat to the sustainability of the programme. Purposeful analysis of data and vigilant claims processing can reveal trends and practices that can then be attended to effectively. This is now another task for our claims team. With increasing clarity about terms and conditions, and strengthening of claims processing, we have been able to reduce the time we used to spend on deciding claims (see Figure 18). The performance criteria of the claims function now focus on "zero pendency" as opposed to "zero rejection". In the same way that zero default in microfinance is largely theoretical, zero rejection in insurance is also highly idealistic. Regardless of how generous the product design is, there are going to be instances that fall outside the scope of cover. Even in such cases, we now have increasing clarity on how much discretion is possible and under what circumstances. The mutual model products offer us better scope for exercising this discretion. Rejections continue to be strictly monitored and every rejected claim is reviewed at the highest level before final closure.

As our positioning on claims crystallized, the team started focusing on efficiency and improving the turn-around time. We also realized that in the interest of prompt disposal, as well as more meaningful investigation, it was essential that claims were reported immediately. Members are being encouraged to register their claims on a toll-free number. This also enables direct contact with the member at the time of claim. On the other hand, with a change in our sales mix towards less service-intensive products, the cost burden of claims processing is also receding. By the end of 2012 we were able to reduce our claims staff by a third compared to 2010. The direct cost of servicing per claim has also come down, despite a reduction in the number of claims (see Figure 18).

Figure 18. Claims servicing cost and turn-around time (TAT)



8 > EXTERNAL ENVIRONMENT

As mentioned earlier, India has emerged as a laboratory of microinsurance, with many different kinds of innovations and interventions being tried and tested. To a great extent this has been because of the active involvement of civil society and member-based organizations, supported by donor agencies. On the regulatory front two pieces of regulation currently address microinsurance. The first is the Rural and Social Sector Obligation introduced in 2001, immediately after the insurance sector was opened to private players. This regulation stipulates that insurers must procure a prescribed minimum quota of business from the rural and social sector. The insurer is penalized if this quota is not achieved in a particular financial year. As the overall business of insurers goes up, the rural and social business also needs to go up. Most of the microinsurance business transacted under the partner-agent model qualifies under these regulations. Without these regulations, many low-priced life and health insurance products would never have seen the light of the day. In 2005, the insurance regulator came out with Microinsurance Regulations, in its first attempt to promote "voluntary" microinsurance. These regulations provided a definition of a microinsurance product and prescribed simplified norms for the recruitment of microinsurance agents. They also provided for higher commissions on life microinsurance products. This paved the way for NGOs, cooperatives and such other organizations to formally become microinsurance intermediaries without having to license regular insurance agents. Insurers were supposed to file microinsurance products separately under these regulations. After the initial optimism, insurers have not been forthcoming to file microinsurance products, apparently because there was no compulsion for them to do so.

The microfinance crisis saw the regulator withdraw certain provisions. The covert permission for a group policyholder to charge a service fee to the insured in addition to the premium was withdrawn. Similarly insurers were mandated to make claim payments directly to the insured/nominee instead of the master policyholder.

Given this situation, there is hardly any scope for a microinsurance intermediary to grow beyond a particular scale and geographical area in a manner compliant with the regulations. In the absence of a progressive remuneration structure like the one we have for our aagewans, it would not be possible to scale up. Furthermore, since the regulations do not permit formal partnerships among intermediaries, it becomes difficult to move outside a limited geographical area. As is the case with other financial services in India, the regulatory thinking for microinsurance also appears to be favouring a small number of big players at the manufacturing level and a large number of small players at the distribution stage.

In addition, the Government is also gradually but firmly taking away a sizeable market segment from voluntary microinsurance providers. With RSBY already in place, discussions are being held about free universal health coverage and a subsidized comprehensive social security package that would cover life and accident risks. For the mainstream insurers these initiatives offer a huge opportunity on account of the stated public-private partnership policy, but they hardly carry any promise for the engagement of the private or development sector at the distribution/implementation level.

If this trend continues, at some point VimoSEWA will have to take a call on whether it wants to continue as an intermediary. If it does, the margins will never allow it to scale up beyond a particular geographical area. This being the case, it might have to reduce its operations to make them even more efficient. A second option would obviously be for it to launch itself into an altogether different league, which would accord ample space to pursue SEWA's larger goals on a bigger scale. The third option would be a complete disengagement from commercial operations to focus on whatever small roles the government schemes offer for grassroots organizations, with other incidental activities like research and evaluation carried out on a not-for-profit basis.

9 > CONCLUSION

While grappling with the issue of the programme's financial viability over the past three years, we have learnt many hard lessons. Taking real steps towards viability is clearly much less exciting than discussing them. Competing social and financial aims can make even seemingly simple matters difficult to understand and resolve. In addition to lack of strategic clarity, one reason why many social organizations are unable to grow beyond a particular point is because they give ethical considerations greater priority over financial ones. More often than not this results in a stalemate and ultimately breeds an inertia that inhibits growth. A better option is to come out with terse statements pertaining to one's activity that are in conformity with the larger values of the organization. We did that with most of our HR, enrolment and claims processes. For an insurance organization there could be statements like "We will never defraud or short change our customers" and "We will be fully transparent in our contracting with customers". Any debate should commence only if and when an action or a decision appears to be violating these declared intentions. Where these principles are not violated, a pragmatic approach should prevail.

The balancing of social and financial goals will be possible only once such perspicuity spreads across the organization. Things need to be simple, clear and focused. For a voluntary microinsurance distribution model like ours, demonstrating operational performance, financial sustainability and social impact is difficult. This difficulty only gets exacerbated by ethical dilemmas, for example, whether high claim ratios are good or bad, whether performance-based discrimination is justified or not, or when ethics should prevail and when expediency? This is why social business as a concept is taking time to evolve into a compact and replicable model. It is quite simple to be purely social or completely businesslike, but if one aspires to be both, it requires deeper thinking, greater clarity and stronger conviction.

Making a microinsurance venture viable is more about the art of management than the science of it. Since financial viability is not contingent upon one or two factors, a comprehensive and holistic assessment and focused action are required. Practitioners never have the luxury of presuming other things constant while dealing with a situation. In fact, more often than not decision-making has to take place amid diverse, conflicting and competing situations. You want top-line growth but also want to keep acquisition costs under control. You want big volumes but do not want to incur high servicing costs. You want to control the claims ratio but do not want to unfairly reject claims. Decisions have to be taken based on information that is often incomplete and may even be incorrect at times. Risks have to be taken on the basis of information, assessment, experience, instinct and intuition. Crisis needs to be converted into opportunity. And even after undergoing all of these, you still have to be ready for Murphy's Law – if something can go wrong, it will! Organizations that master this art with conviction and resilience will attain their objectives sooner or later.

10 > APPENDIX: SUMMARY OF PRODUCTS

1. Sukhi Jeevan: Term life insurance[22]

Annual premium	Natural death benefit	Accidental death benefit 1
100	10 000	50 000
150	30 000	75 000

- New members are eligible to enrol between the ages of 18 and 55 years. Existing members can avail themselves of insurance until the age of 59 years.
- Claims for death due to cancer, tuberculosis or chronic heart disease are not payable in the first year of the policy. HIV/AIDS, addiction and substance-abuse-related conditions are not covered.

2. Jeevan Madhul: Savings-linked life insurance

Annual premium	5 years	10 years	15 years
1 200	6 000	12 000	18 000
1 500	7 500	15 000	22 500
2 500	12 500	25 000	N/A

- Term of the policy: 5 to 15 years.
- Death sum assured: Annual premium multiplied by term of the policy (years).
- Accidental death is two times the natural death sum assured.
- Total and partial disability additional coverage offered.
- Age limit: 18 to 60 years. Age limit for maturity benefit: 65 years.
- Sum assured limit INR 5,000 to INR 30,000.
- Mode of payment: annual, half-yearly, quarterly, monthly, fortnightly, weekly.
- Maturity benefit sum assured plus a bonus (as declared by the insurer).
- Assured benefit: after paying premium for two years, if a member cannot continue to pay premium, coverage continues for the next two years from the date of last payment of the premium or till the maturity of the policy (whichever is earlier).
- Surrender value (when policy is discontinued) is available after paying three years' premium. It is subject to the total premium paid.
- The grace period for the premium payment is 30 days from the due date of premium for yearly, half-yearly and quarterly premium and 15 days for other premiums.
- After paying two years' premium, if the member has stopped paying premium, but later wishes to revive her policy, she can do so. She has to pay the outstanding premium with interest as per the insurance company's norms.
- Exclusions:
    - Suicide is excluded in the first year.
    - For accidental death claims, self-injury, attempted suicide, psychological disorders, alcohol-related injuries and death are not covered.
    - Death due to communal violence, war, revolution and snake bite is excluded.
    - Accident due to any criminal act is excluded.

[22] Figures in this table and the others in this section are in INR.

3. Swastha Parivar: Health insurance

Annual premium	Natural death benefit
400	10 000
1 000	25 000

- A family comprising member, spouse and up to four children can be covered under the policy. A minimum of 24 hours' hospitalization is required.
- The first 30 days after the product is purchased, other than accidental-injury-related hospitalization, are excluded from coverage.
- Children between three months (91 days) and 17 years are eligible for coverage. For new adult members, 18 to 55 years should be the age at enrolment. Already insured members can continue their policy till 70 years of age.
- In cases of illnesses such as fever, gastroenteritis, malaria and typhoid, the member will get a fixed claim amount of INR 500 per day if hospitalized for up to 48 hours. Beyond 48 hours' hospitalization regular conditions will apply.
- Pre-existing conditions are covered only after the first year of the policy.
- For cataract, laparoscopy and fractures, the 24 hours' hospitalization condition is not applicable.
- In rural areas, treatment by traditional bone-setters is permitted for fractures. The claim amount for this is fixed at INR 600.
- In urban areas, treatment from traditional bone-setters is not permitted.
- Ahmedabad city members have to bear 20 per cent of their hospitalization costs or sum insured (whichever is less) for using non-network hospitals.
- Hospitalization related to HIV/AIDS, substance abuse (alcohol, drugs) and psychological disorders is excluded.
- Bed charges for hospitalization are restricted as follows:

Sum insured	Bed charges per day
10 000	100
25 000	250

4. Sukhi Parivar: A bundled insurance product covering life, health, asset and accident for individuals as well as families

Insured	Premium	Life	Health	House and asset	Accidental death
Member	175	10 000	Up to 2 000	Up to 10 000	40 000
Spouse	125	1 000	Up to 2 000		40 000
Child	100	2 500	Up to 2 500		
Family	400				

- Coverage only applies at network hospitals
- Claims for death due to cancer, tuberculosis or severe heart disease are not payable in the first year of the policy. HIV/AIDS, addictions and substance-abuse-related conditions are not covered.
- Asset-related claims are payable for losses occurring due to fire, earthquake or communal violence at the address given at the time of enrolment. The claims payment is subject to the terms and conditions of the insurance company.

5. Saral Suraksha Yojna: hospital cash product

- Annual premium is INR 350 in case of a family with up to two children and INR 475 for a family with up to four children.
- Benefit of INR 200 for every day of hospitalization to any insured member of the family.

- Maximum amount payable for hospital cash benefit is INR 3,000 per policy per year.
- A family comprising member, spouse and up to four children can be covered under the policy
- Policy limit applies to the entire insured family as a whole.
- Maximum age at entry is 55 years. Policy can be renewed up to the age of 70 years.
- Hospital cash benefit is payable only if the insured gets admitted to a network hospital. All government hospitals and hospitals empanelled for RSBY are deemed to be network hospitals.
- In addition to the hospital cash cover, the primary member under the policy gets an accidental death cover of INR 100,000 and spouse is insured for INR 50,000.

MICROINSURANCE INNOVATION FACILITY

Housed at the International Labour Organization's Social Finance Programme, the Microinsurance Innovation Facility seeks to increase the availability of quality insurance for the developing world's low income families to help them guard against risk and overcome poverty. The Facility was launched in 2008 with the support of a grant from the Bill & Melinda Gates Foundation.

See more at: www.ilo.org/microinsurance

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microinsurance@ilo.org
www.ilo.org/microinsurance