



INDIA

HEALTH MUTUAL INSURANCE



Mutual Benefit, Shared Risk in India: Annapurna Pariwar's Community-owned Health Mutual Insurance Program

As India pursues its goal of universal health coverage (UHC), the focus on mitigating barriers to access health care has sharpened. Financial constraints, a key impediment to access, force many low-income households to choose between forgoing treatment or incurring high out-of-pocket (OOP) expenditure to obtain it. This often triggers further impoverishment. Health insurance is thus being widely embraced as a powerful strategy to promote equity in access and provide financial protection:

The Government of India and the state governments have launched targeted health insurance schemes to bring quality health care within poor people's reach and break the vicious cycle of poverty and poor health. However, these schemes are largely limited to the below-poverty-line (BPL) population. They have mostly left out the country's sizeable near-poor and above-poverty-line populations, and have also failed to capture significant numbers of eligible BPL households. In this environment, communities have been coming together to implement risk-pooling mechanisms to enhance access to quality health care and protect households from high OOP health expenditure.

Health mutuals are a form of community-based health insurance, in which risks are not transferred to an insurer but are shared and managed by the community itself. They are a mechanism for financial risk protection and empowerment of marginalized groups.

Improving the poor's access to quality health care is a key focus of the USAID-funded Health Finance and Governance (HFG) Project in India.

The HFG project is supporting the scale-up of health mutual schemes in India with the aim of expanding financial protection and access to health care. As part of its groundwork, HFG developed a case study on the health mutual run by Annapurna Pariwar, a development organization and micro-finance institution operating in the cities of Pune and Mumbai in Maharashtra state. Launched in 2003, and now more than a decade old, the insurance scheme serves as an interesting case to examine the design and implementation of a health mutual in the Indian context.

This brief summarizes the main findings of the case study, looking closely at Annapurna Pariwar's health mutual's strategies and experiences. The scheme strives to provide financial protection and health care access for its members while maintaining sustainability of the scheme.

Key Insights

The case study yielded interesting insights on Annapurna Pariwar's health mutual strategies and implementation experiences. The key insights from the case study are presented below.

Annapurna Pariwar's health mutual insurance program

Annapurna Pariwar is a Maharashtra-based group of five organizations promoting empowerment of urban slum women through diverse financial and social support services. It launched its health mutual scheme in 2003, establishing one of India's first health financing initiatives formed on the basis of mutuality and collective pooling of health risks. The health mutual operates under Annapurna Pariwar Vikas Samvardhan, which is registered as a Section-8 company (not-for-profit), and, thus, is free from the obligation to contribute a minimum share of capital or maintain an elaborate governance structure. Annapurna has, to ensure compliance, benchmarked the program to the requirements issued by the country's Insurance Regulatory and Development Authority, which, incidentally, does not make any explicit reference to the health mutual model. Figure 1 summarizes the key features of Annapurna's micro-insurance scheme.

Key strengths

Annapurna's health mutual has increased enrolment year on year as the organization has grown (Figure 2) and demonstrates strengths that have contributed to its relevance and sustainability.

- Financial risk protection for informal workers:** Annapurna's insurance scheme targets informal workers who make up the large majority of India's workforce but are neither served by government-funded health insurance schemes for BPL households nor costly commercial health insurance. Annapurna and similar community-based programs seek to address this void, bringing quality health care to low-income households and offering financial protection against catastrophic healthcare costs. The scheme currently has about 200,000 members, a majority of whom own small businesses and earn INR 15,000 (about USD 225) or less per month. Apart from covering hospitalization at empanelled facilities, the scheme also attempts to reduce OOP expenditure on outpatient care through price discounts of 10–30 percent at a network of diagnostic centers and pharmacy shops.

Figure 1. Key Features of Annapurna Pariwar's Health Mutual Insurance Program

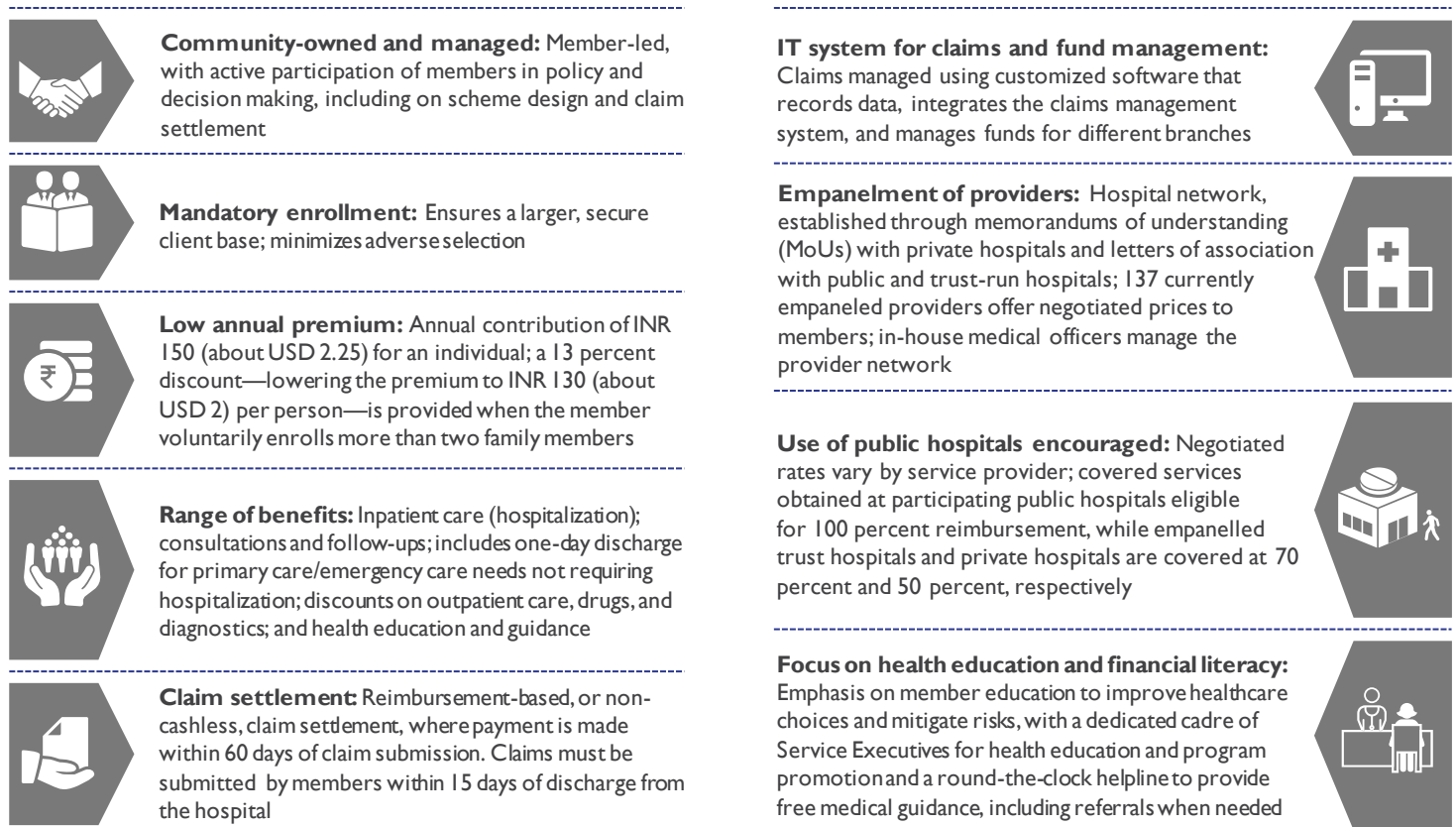
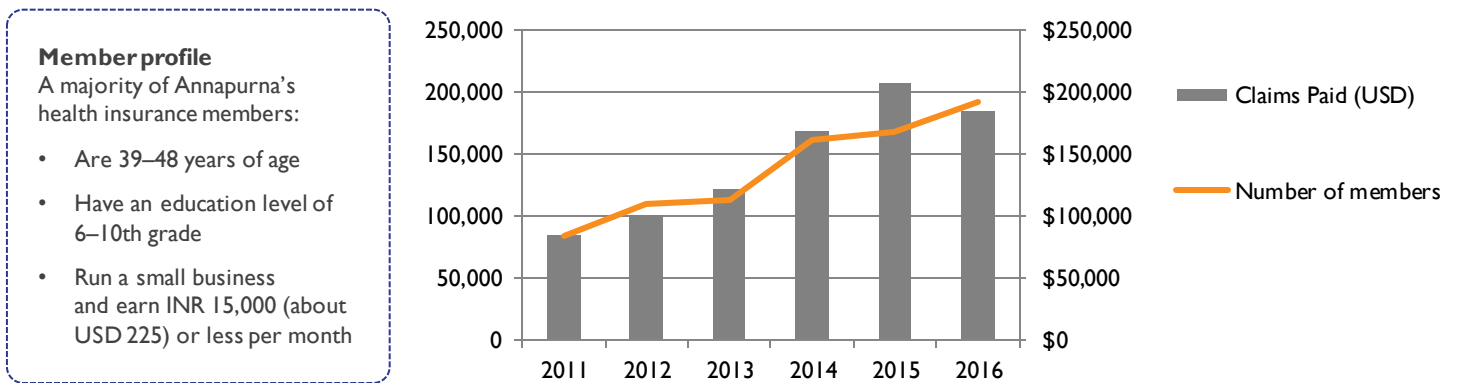


Figure 2. Key Figures - Annapurna Pariwar Health Mutual 2011-2016



- **Community ownership and management:** The Annapurna health mutual is owned, designed, and managed by its members who make decisions on product design and claims, without engaging a third party in the underwriting process. Members participate in decision-making through elected community representatives (CRs), who each have one vote and serve for a two-year term. Currently, the scheme has 70 CRs. CRs meet every month to validate policy decisions and approve/reject claims based on established procedures. Such a participatory form of management not only strengthens community outreach and engagement, but also keeps operating costs low and prevents fraud.
- **Mandatory enrollment strategy:** The insurance scheme serves an established group: Annapurna's micro-finance clients for whom enrollment in the health insurance scheme is mandatory. Enrollment was voluntary at first, but weak demand for insurance among credit clients resulted in low enrollment, threatening the scheme's financial sustainability. The mandatory enrollment to health insurance is also a strategic benefit, since it may reduce defaults on loan payments for those members incurring catastrophic health costs. In a change of strategy, the Annapurna community passed a resolution to make insurance compulsory for all micro-finance clients. Contrary to expectations for a decline in micro-finance clients after health insurance became mandatory, borrowers have more than doubled, from 23,000 in 2011 to about 57,000 in 2016.¹ Annapurna's compounded annual membership growth rate of 15 percent during 2011–2016 continued after the launch of the national Rashtriya Swasthya Bima Yojana (RSBY) health insurance scheme and the Maharashtra government's scheme for BPL families. Notably, enrollment of family members into Annapurna's scheme is voluntary, but almost all credit clients agree to enroll their families.
- **Control of administrative costs:** Community management helps keep administrative costs down. The community's engagement in claims management helps to instill cost consciousness and weed out unnecessary costs and fraud. Mandatory enrollment also saves administrative costs related to marketing and enrollment. The financial

viability should consider the real, unsubsidized profit or loss of the scheme. There is an agreed upon set of key performance indicators to measure performance. One of these indicators -operating self-sufficiency (OSS) ratio- assesses how far insurance has come in covering its operating expenses with its operating income. Since both the amounts in the numerator and the denominator come from the Income Statement, it is relatively easy to monitor. Annapurna's OSS ratio has consistently stayed over 100 percent since 2011 reflecting efficient administration and sustainable operation.

- **Multipronged approach to risk management:** Annapurna has a comprehensive approach for reducing and mitigating risk (Figure 3). Mandatory enrollment, noted above, not only increases enrollment and revenue; it also creates a larger insured risk pool for the scheme and helps mitigate risk of adverse selection. Attention to financial literacy, medical guidelines, and health promotion mitigates both present and future risks. The reimbursement-based claims payment approach reduces risk by controlling fraud. Importantly, Annapurna uses an IT system for fund management which helps manage premiums and claims. The IT system enables cross-subsidization between different branches, so that branches with surplus funds support those with deficits. The program also maintains a large solvency reserve. At the end of 2016, Annapurna's accumulated balance fund stood at about INR 14 million, about 1.26 times the annual claim amount.

Major challenges

The case study pointed to some challenges that constrain the Annapurna health mutual from achieving greater scale and increasing the financial protection it offers to members.

- **Focus on hospitalization benefits:** Coverage of just hospital expenses can only partially protect poor households from high OOP expenditure. The scheme does not pool risk for primary care services; members must obtain these services at public or private facilities, and pay any fees due OOP. Annapurna care access by negotiating discounts with providers for consultations, medicines, and diagnostics. These discounts supports primary

¹ Annapurna Pariwar. Available at: <http://www.annapurnapariwar.org/microinsurfin.html>. Accessed on January 31, 2017.

Figure 3. Annapurna Health Mutual's Multipronged Approach to Management

- Mandatory enrollment ensures enrollment, mitigates adverse selection
- Claim review to monitor for fraud
- IT-based claims management
- In-house medical doctors validate claims
- Final claims decisions by CRs
- 24/7 helpline for medical guidance



- Low operating costs
- Negotiated rates with providers
- Focus on preventive care
- Discounts on outpatient services
- Financial literacy of members
- Community feedback on providers
- Health education and promotion

are a value added service for members that complements insured benefits for inpatient services. Apart from direct hospital costs, ill health also brings in its wake indirect costs, for example, income foregone during hospitalization and recuperation. An insurance program with broader benefits, including for primary care, can foster greater financial protection, and in theory may improve health outcomes through timely and appropriate health intervention.

- **Issues in the reimbursement-based claims settlement process:** The program could accelerate timeliness of claims payment, by, for example, exploring a system where payment can be made to beneficiaries within one week of discharge.
- **High covariate risk due to geographic concentration:** Restricting membership in the scheme to micro-finance clients has mitigated several risks, but has also restricted it to a small base of clients concentrated in specific geographies of Pune and Mumbai. Geographic concentration of clients limits the scope to diversify risks and exposes the scheme to high covariate risk. For example, a natural disaster or disease outbreak in the scheme's geographic area could affect many members at the same time.
- **Scale-up constrained by being linked to credit program:** Limiting enrollment in the scheme to only credit clients constrains the scheme from expanding outside the micro-finance institution (MFI). Insurance is a volume business, and schemes perform better when they have a large number of members to pool and share financial risk. Annapurna would need to devise a strategy to broaden enrollment to expand financial protection. Notably, Annapurna has decided to expand enrollment to MFIs in three new areas of Maharashtra (Beed, Kolhapur, and Maval) through a franchise model.

The Way Forward

India's goal of achieving universal health coverage demands a resolute commitment to ensuring that the country's poor have risk protection against catastrophic healthcare costs. Given India's complex health care landscape and the government's competing health sector priorities, a solution for the financing challenge may not lie in government interventions alone, but rather in a pluralistic approach.

While some health mutuals such as Annapurna Pariwar have grown and maintained sustainable operations, the path ahead for health mutuals in India to scale up and reach many more underserved clients will demand reinvention, innovation, and, even perhaps, exploration of partnerships with insurance companies. Importantly, there is growing need for a complementary relationship between government-funded health insurance schemes and community-based micro-insurance programs. Such efforts could focus on aligning the benefit packages, target populations, and implementation strategies to promote complementarity. As corporate and civil society interests and capabilities converge, together they can create innovative business models that target the bottom of the pyramid. Expansion of the health mutual model through community-based organizations, NGOs, cooperatives, and micro, small, and medium enterprises may unlock large existing networks to efficiently distribute insurance.

The Health Finance and Governance (HFG) project works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. Designed to fundamentally strengthen health systems, the HFG project improves health outcomes in partner countries by expanding people's access to health care, especially to priority health services. The HFG project is a five-year (2012-2017), \$209 million global project funded by the U.S. Agency for International Development under Cooperative Agreement No: AID-OAA-A-12-00080.

The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, Training Resources Group, Inc. For more information visit www.hfgproject.org/

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