

FICCI HEALTH INSURANCE CONFERENCE 2017

Health Insurance 2025:
Inclusive. Accessible. Affordable

Distribution 2.0

Improving distribution in health insurance

December 2017

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Foreword by FICCI

Health Insurance is a key pillar not just for a family's physical health, but also for their financial well-being. It enables access to appropriate health care while reducing the impact of an untoward health event on a family's earning and payment capacity. However, in India health insurance remains underpenetrated, and expensive in the eyes of consumers.

Insurers have been working tirelessly to expand coverage and distribution, leveraging newer distribution models and technology to reduce the cost of acquisition, and consequently bring down to the cost of cover for consumers. This is in addition to a number of governmental initiatives, and the work that the regulator is doing to enhance awareness, as well as quality of service to consumers.

Despite the efforts put in till date, there is still significant opportunity to expand distribution, while reducing the cost of customer acquisition and servicing. The Federation of Indian Chambers of Commerce and Industry (FICCI) has set up a task force with key representatives from the Regulator, insurers and health insurance intermediaries to deep-dive into issues that the industry faces.

This paper provides recommendations designed to enhance the distribution (and acceptance) of Health Insurance and we hope that this paper will pave the way for stakeholders, policy makers and regulators to take initiatives to build on the need for Health Insurance of an individual and support the transformation that the Health Insurance industry requires. This will be in keeping with India's vision to be globally competitive, locally relevant and to deliver cost-effective health insurance.

We are thankful for the support of the Insurance Regulatory Authority of India, Ernst & Young and the task force members for the development of the report. Going forward FICCI would like to work closely with IRDAI, health insurers and industry partners and intermediaries to make action plans for achieving the reforms. We would also like to thank the FICCI Health Insurance Committee and the Task Force for their contributions and untiring effort.



Mr G Srinivasan
Chairman, FICCI Health Insurance Committee;Chairman & Managing Director, The New India Assurance



Mr Girish Rao
Co-Chair, FICCI Health Insurance Committee; Chairman & Managing Director, Vidal Healthcare Services



Mr Sandeep Patel
Co-Chair, FICCI Health Insurance Committee; CEO & MD, Cigna TTK Health Insurance



Mr Antony Jacob
Co-Chair, FICCI Health Insurance Committee; CEO & Whole Time Director, Apollo Munich Health Insurance



Ms Shobha Mishra Ghosh
Assistant Secretary General, FICCI

Message from EY



India has been witness to a significant demographic shift over the past two decades, driven by economic growth, external market factors as well as the focus of successive governments on financial inclusion. This increase in financial health has led to changes in dietary habits and lifestyles as well. The shift to unhealthier lifestyles is visible in the increasing prevalence of non-communicable diseases.

Awareness around health care, as well as health insurance (driven by government initiatives), is increasing yet the penetration remains poor, especially for individual policies, i.e., people covered under policies that they have purchased on their own. This is despite the fact that there is significant out-of-pocket expenditure on health care (estimated to be 60%–70% of total spend on health care).

Over the past few years, the regulator has undertaken a wide range of initiatives to improve access to health insurance. These range from allowing micro-insurance and open architecture, to setting up stand-alone health insurers (SAHI). The industry has also invested significantly in improving access through distribution channels such as digital/app-based sales, online sales, micro-insurance agents, brokers, web aggregators and agents. The processes for underwriting cases and onboarding customers have also been optimized across the board. However, all of these initiatives have had only a limited impact on the penetration of health insurance.

With access not being an issue, the poor penetration is best explained by the individual consumer's willingness to buy the product, the ability to use the services offered and the perceived value (versus the current state of self-funding treatment)

This paper accordingly focuses not on pure distribution aspects, which the industry has spent significant amounts of money on optimizing, but rather on the underlying elements of awareness, value and trust, which will increase the propensity to buy and consume health insurance. This will become essential as the currently young population of India ages over the next two decades with a resultant need for increased spend on health care and long-term care.

We are grateful to FICCI for giving us this opportunity to collaborate and be a part of the task force on distribution in health insurance.

The interactions with the members of the task force and the regulator gave us a chance to explore options that can play a significant role in growing the penetration of health insurance.

At EY, we are driven by our purpose of Building a better working world. We firmly believe that often, the genesis of a creative solution is asking the right questions. We hope this report and the recommendations in it will just be the start of that journey.

Mr. Rohan Sachdev
Partner & Leader, Financial Services Advisory and
Global Insurance Leader for Emerging Markets



Message from FICCI
Task Force Leader

Health insurance is a critical protection tool for the citizens of any country, especially one which is undertaking a sustained effort to pull people out of poverty. The regulator is cognizant of this, and has undertaken a number of initiatives including permitting the establishment of stand-alone health insurers (SAHI), and allowing the sale of products through a number of channels including Point of Sale (POS) agents, micro-insurance agents, insurance marketing firms and web aggregators.

On its part, the health insurance industry (including general insurers) have been leveraging these new channels to expand outreach and reduce the cost of selling. However the acceptance of health insurance remains low, as can been seen from the low penetration (for individual policies). While opportunities remain, to reduce the cost of acquisition and servicing (largely by leveraging digital and analytics initiatives), these are not likely to be sufficient to increase penetration significantly.

The need of the hour is to address the underlying reasons which drive purchasing behaviour. This paper attempts to identify the key drivers and inhibitors of health insurance purchase and lays out recommendations that the Task Force believes will help improve acceptance, and penetration of Health insurance.

We are thankful to the FICCI Health Insurance committee for providing us an opportunity to address this challenge, and would like to call the extensive support received from Insurance Regulatory Authority of India, Ernst & Young and the task force members for the development of the report.

Mr. Sandeep Patel
CEO, Cigna TTK Health Insurance



Health insurance distribution task force

The FICCI task force on health insurance distribution was constituted on the advice and direction of the Chairman – IRDAI. The task force comprised of members led by Mr. Sandeep Patel, CEO, Cigna TTK Health Insurance. The task force has created a recommendation paper on "Improving distribution in health insurance" with a focus on enhancing consumer awareness and acceptance of health insurance and trust in the providers.

Working Group Members

- **Mr. Sandeep Patel**, CEO, Cigna TTK Health Insurance
- **Mr. Yashish Dahiya**, Co-Founder & CEO, Policybazaar.com
- **Mr. R Mahesh Kumar**, Director – Legal & Compliance and Company Secretary, Exide Life Insurance
- **Mr. Prashant Jhaveri**, Chief Business Officer, Medi Assist India
- **Mr. Peeush Jain**, SVP – Head, Business Partnerships & Transformation, Lakshmi Vilas Bank
- **Mr. Syed Quasim Ali**, Senior Assistant Director – Health Services, FICCI

EY as the knowledge partner for the initiative leveraged its global experience in identifying current state challenges and recommending how these could be addressed. The EY team comprised of:

- **Mr. Rohan Sachdev,** Partner & Leader, Financial Services Advisory and Global Insurance Leader for Emerging Markets, EY
- **Mr. Rana Ganguli,** Partner, EY
- **Mr. Aditya Khanna,** Director, EY
- **Mr. Irvinder Lail,** Director, EY

Executive summary

As at the end of 2016, health insurance penetration in India was low, covering just 359 million[1] people out of an estimated population of 1,324 million[2]. Of this, government schemes (which largely target the Below Poverty Line [BPL] population) accounted for 76% of the people covered, while an additional 16% were covered under group (non-government) business[3]. The individual business accounted for just about 8% of the lives covered (~ 28.7 million people) despite the fact that it has the lowest net incurred claims ratio (net ICR) of these classes of business[4]. The penetration of health insurance (on the number of lives) is very low at ~7.5% among the non-BPL customer segment[5] .

Less than **25%** of the Indian population has health insurance.



Only **8%** of the lives covered are under individual policies



This poor penetration is on account of a number of factors, primarily the willingness to buy (perceived value of product and cost of product) as well as the ability to buy (simplicity of purchase and trust in seller). This can be evidenced by the fact that of the individual policies sold, 70% were sourced through insurance agents, 13% through banks and 10% through direct purchase from insurers (excluding online). Direct online and web aggregator sales accounted for less than 2.25% of the individual policies issued. As a result of the dependence on higher cost channels, product pricing tends to be higher, which further reduces the attractiveness of health insurance[6].

[1]IRDAI annual report 2016
[2]World Development Indicators, World Bank 2016
[3]IRDAI annual report 2016 (Table I.53)
[4]IRDAI annual report 2016 (Table I.53, Table I.54)
[5]EY Analysis
[6]IRDAI annual report 2016 (Table I.61)



There is a need to increase consumer faith in the industry, and a perception of the value of the product. This will require a concerted effort by all the stakeholders, from the regulator, the insurers (who provide the cover), distributors, health care providers (hospitals, nursing homes and doctors), third-party administrators (TPA) and even pharmacies.

Since India is a diverse country with differing needs, for the purposes of this paper, we have focused on the individual business for the affluent and mass affluent segments.

India stands apart from most other countries on account of its diversity, across practically every parameter, whether it be age, socio-economic distribution, education levels, financial literacy, wellness, geographical spread or even growth rates across different parts of the country.

Need to
increase consumer
faith in the industry, and a perception of value of the product.

The penetration or density of insurance in India is poor which coupled with this complexity and variability across the country only make it more challenging for the insurance industry to ensure that appropriate products and distribution systems are in place to cater to each customer's need.

1



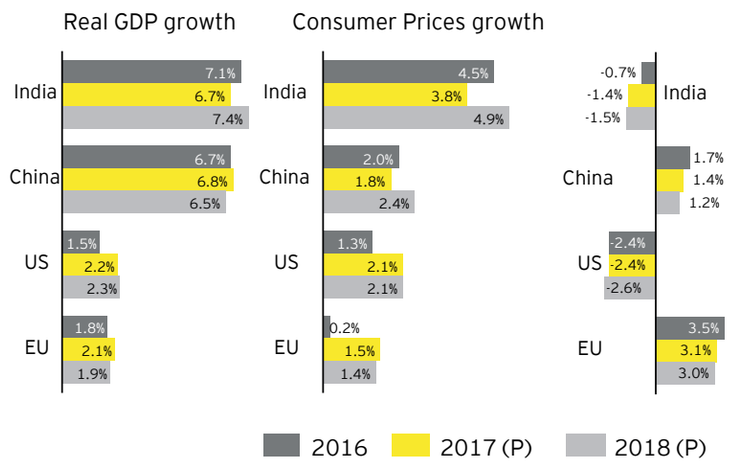
India overview

A robust economy

The Indian economy has been growing at a steady pace for the past decade and currently ranks as the seventh largest in the world measured by nominal GDP and the third largest as measured by Purchasing Power Parity (PPP).

The Indian economy has grown eight-fold in the past 25 years, from US$293 billion to ~US$2.3 trillion, and it is forecasted to continue growing by 7.9% by December 2017[7].

As per IMF data, average incomes have gone up by a factor of six, leading to increased spending capacity of Indian customers, especially in the middle-class segment[8].



Young, growing population

India's population (~1.34 billion in mid-2017) continues to grow at a steady pace. India is expected to surpass China to become the world's most populous country by 2024[9]. Since population growth is a key driver in the expansion of the health insurance target market, an understanding of the dispersion of the population becomes necessary to address market needs.

Some key metrics of India's population dispersion[10]

- Current population: 1.34 billion (18% of the world's population)
- Population growth rate: 1.15%[11]
- Working age group (15-60 years): 63% of the population[12]
- Old age population (above 60 years): ~8.3% of the population[13]
- Median age: 26.6 years
- Crude birth rate per 1,000: 20.4
- Life expectancy at birth: 67.6 years
- Under five mortality: 53 for every 1,000 live births
- Infant mortality: 40 for every 1,000 live births

By 2050, while the working age group is expected to constitute ~62% of the population, the share of the old age population (over 60 years) is estimated to rise to ~19%[14]. This will, in turn, increase the need for healthcare as well as health insurance.

[7] "India's GDP growth to rise to 7.9 per cent by Dec 2017: Report," The Economic Times, 16 May 2017
[8] "World Economic Outlook, October 2017: Seeking Sustainable Growth: Short-Term Recovery, Long-Term Challenges," IMF, October 2017
[9] "World Population Prospects: The 2017 Revision," UN Department of Economic and Social Affairs, 21 June 2017
[10] "World Population Prospects: The 2017 Revision," UN Department of Economic and Social Affairs, 21 June 2017
[11] "Population growth (annual %)," The World Bank
[12] "SRS Statistical Report 2015," Ministry of Home Affairs
[13] "SRS Statistical Report 2015," Ministry of Home Affairs
[14] "World Population Prospects: The 2017 Revision," UN Department of Economic and Social Affairs, 21 June 2017



Socio-economic dispersion

The demography of a country helps to understand the challenges and opportunities it presents for sustainable development. Health characteristics such as burden of diseases, productive years lost and cost of health care are the key drivers of economic growth for emerging markets such as India.

Some key metrics

- Only 31.1% of the Indian population lives in urban areas[15].
- Urban India contributes more than 60% to the GDP and an extra 300 million new urban residents are projected by 2050, leading to a call by the Indian Government to build 100 new smart cities over the period[16].
- India's per capita income is about to cross the INR1 lakh mark by FY2017 and it has almost doubled from FY2010.
- The literacy rate in India has shown considerable growth in the past decade. By 2015, 71% of rural and 86% of urban population was literate
- The middle-income population increased from 50 million in 2005 to around 250 million in 2015 and is expected to reach 580 million by 2020.

The growth in the Indian economy in the past few years has resulted in an increase in living standards as well as aspirations across the socio-economic strata.

[15] "Statistical Year Book India 2017: Area and Population," Ministry of Statistics and Program Implementation, June 2017
[16] "World Cities Report 2016- Urbanisation and Development: Emerging Futures," UN Habitat, 2016

2



The need for health insurance in India

Changing demographics

The availability of health care and financing options of health care for the elderly has greatly improved worldwide from the past. As a result, many low and middle-income countries, including India, have attained a life expectancy at birth of 65–70 years, which is much longer than what people expected around 50 years back. According to a report on the ageing population by WHO, life expectancy in countries such as Brazil and Myanmar has risen by as much as 20 years in the past five decades.

In India, as of 2014, the life expectancy at birth was 67.8 years. This low figure is a clear indication of the lag prevalent in easy availability and financing options for health care to the elderly.

As India attains the replacement fertility level, the segment of elderly in the population will rise, generating extra burden on the existing health care and financing options.

Currently, India houses the second largest elderly population in the world, accounting for nearly 8% of its total population. This share is expected to show a dramatic jump to 20% by 2050, according to World Population Prospects (2015), UN. According to the population census of 2011, there are nearly 104 million elderly people in the country, of which 51 million are males and 53 million females. The literacy rates for the elderly have strengthened from 27% in 1991 to 44% in 2011. The literacy rate of elderly females is 28% while that of elderly males is 59%.

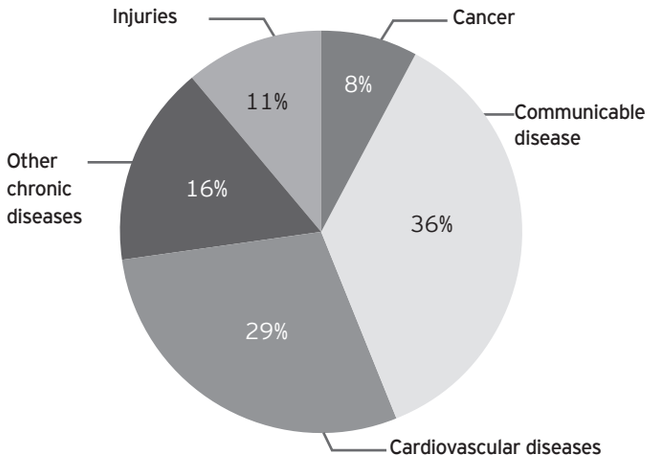
Increasing incidence of diseases

Over the past two decades, India has witnessed a major epidemiological transition from communicable to non-communicable diseases (NCDs). This is driven, in large part, by changes in economic conditions which have resulted in a shift towards unhealthy lifestyles.

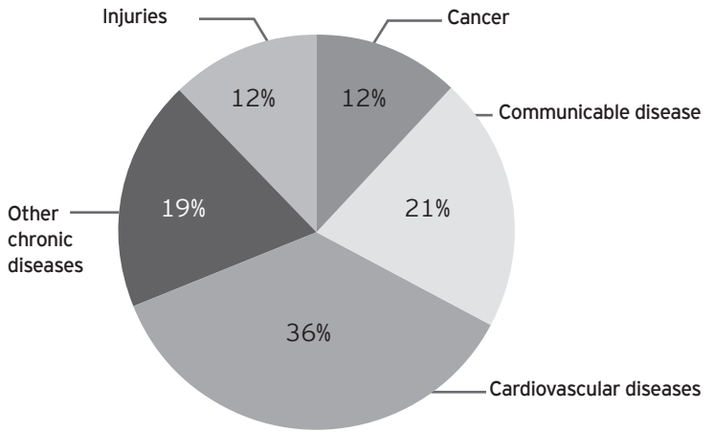
Currently, India is suffering from high morbidity and low mortality, caused by the triple burden of infectious, communicable and NCDs. As the population ages, India is expected to see an increase in the occurrence of NCDs and the resultant morbidity[17].

[17]Yadav, S. and Arokiasamy, P. Understanding epidemiological transition in India. Global Health Action, 2014





India disease profile - 2005



India disease profile - 2030 (projected)

Primarily, there is a growing concern in the Government and health care administrators to address the increasing burden of NCDs, which are responsible for two-thirds of the total morbidity burden and just over half of deaths[18]. Recognizing the gravity of the situation, in 2010 the Government started the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Strokes (NPCDCS)[19]. The program is designed to reduce premature deaths due to major NCDs through by promoting health and enabling early diagnosis, management and referral of NCD cases.

As of March 2017, the program is being implemented across all 36 States/UTs (State NCD cells set up) with 390 District NCD cells being established in district headquarters. To strengthen healthcare infrastructure and enable diagnosis & treatment, the program has established 388 District NCD Clinics, 2115 CHC[20] NCD Clinics, 133 Cardiac Care Units (CCU) for emergency Cardiac Care and 82 Day Care Centres for cancer chemotherapy across the country.

[18]WHO Mortality and Morbidity Data, 2015
[19]Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, 13 September 2017
[20]Community Health Center



Rise of NCDs

Strong economic growth in India in the past 15 years has brought significant changes in dietary habits, nutritional status and lifestyle. As a result, NCDs have become more common, negatively impacting morbidity and mortality. According to the World Health Organization, one in four Indians will die from an NCD before the age of 70[22] .

NCDs currently account for 53% of the total deaths and 44% of disability-adjusted life years (DALYs) lost[23] . Higher socioeconomic groups are more susceptible to cardiovascular diseases and accompanying risk factors such as obesity, diabetes, hypertension and elevated lipids[24]. When compared to global averages, Indians get cardiovascular diseases or diabetes 10 years earlier in their lifespan. This increases the chances of premature mortality in the productive workgroup of 35–63 years.

The table below illustrates the transition from communicable diseases to NCDs for mortality between 1990 and 2013[25.]

1990		2013	
Rank	**Disease**	**Rank**	**Disease**
1	Lower respiratory infections	1	Ischemic heart disease
2	Diarrheal diseases	2	Chronic obstructive pulmonary disease
3	Preterm birth complications	3	Cerebrovascular disease
4	Tuberculosis	4	Lower respiratory infections
5	Neonatal encephalopathy	5	Diarrheal diseases
6	Ischemic heart disease	6	Tuberculosis
7	Other neonatal disorders	7	Diabetes
8	Chronic obstructive pulmonary disease	8	Chronic kidney disease
9	Tetanus	9	Neonatal preterm birth
10	Neonatal sepsis	10	Road injuries
11	Stroke	11	Neonatal encephalopathy
12	Road injuries	12	Other neonatal disorders
13	Self-harm	13	Tetanus

Communicable, maternal, newborn and nutritional disorders Non-communicable diseases Injuries

[22]Who.int. WHO | India: First to adapt the Global Monitoring Framework on non-communicable diseases (NCDs).2015
[23]Health Risk Factors India, Swiss Re, 2015
[24]Subramanian, S., Corsi, D., Subramanyam, M. and Davey Smith, G. Jumping the gun: the problematic discourse on Socio-economic status and cardiovascular health in India. International Journal of Epidemiology, 42(5), pp.1410-1426, 2013
[25]The State of Health in the Commonwealth: India prole, IHME (2015)



Opportunity for health insurance

India's population today is relatively young, primarily due to the high birth rate in the country. As this young population enters the workforce, it will become a major growth driver for the economy. Also, this young population will need better health protection when they enter the elderly phase.

Currently, most insurers cover individuals only up to the age of 60–65. However, medical expenses can become a significant burden on the elderly, the majority of whose health care expenses are borne by family members via out-of-pocket payments. Therefore, there is a need to increase health cover in terms of age.

Urban people have better access to private medical infrastructure than people in rural areas. The higher cost in private medical hospitals could translate into increased interest of the urban population in insurance products.

Two-thirds of the population lives in rural areas and is difficult to reach via current distribution setups. Also, as the large current working class ages, the demand for health care and financing options is likely to increase significantly, serving as a major driver of growth for the insurance industry.

Improved literacy also brings in improvement in financial literacy in the population

Key growth drivers for health insurance

1	2	3	4	5
Increased awareness	**High out-of-pocket expenditure**	**Increasing health care costs**	**Technology**	**Regulatory reforms and tax incentives**
Awareness of health insurance and perception of insurance needs are improving among people, evidenced by ~21% growth in the retail health insurance.	62% of the total health care expenditure in the country was borne by households out of their pockets in 2014.	Health care expenditures continue to rise as the Government modernizes India's health care system.	New technologies are disrupting health insurance. Insurers are launching mobile apps and Internet-based services.	The recognition of health insurance as a standalone class is allowing more opportunities through open architecture. Tax benefits under 80D have increased from INR15,000 to INR25,000.

Source: EY Analysis

The focus of the health insurance sector in India has always been on the affluent segment of the population, while the mass affluent segment has kept growing in terms of strength, disposable incomes, living standards, and concern toward health and wellness. However, the increasing health care costs are making it difficult for the mass affluent segment to finance their health care costs via out-of-pocket spending. This in turn has increased the attractiveness of health insurance products for this segment, which currently holds the highest potential for growth of the health insurance industry in India.

3



The existing framework

Health care funding modes

Globally, health care spend is typically financed in one of four ways:

General taxation

Health system completely financed from tax revenues and other government resources (e.g., NHS in the UK)

Social insurance

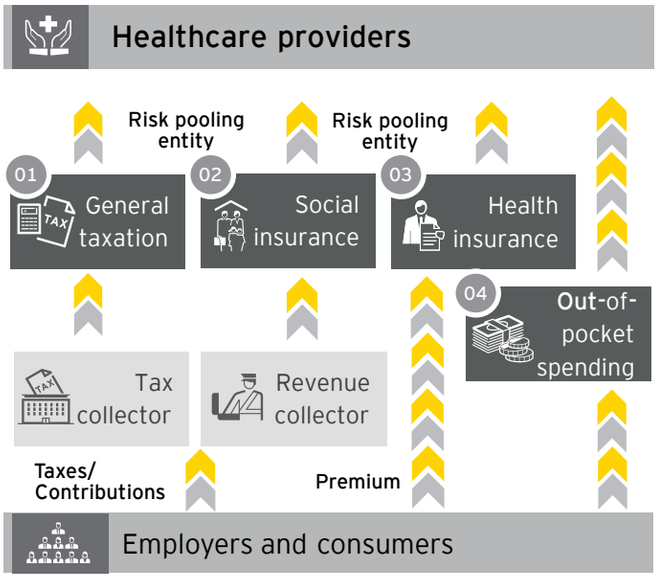
Based on tax-like contributions and managed/ regulated by the state (e.g., Medicare in the US)

Private health insurance

Paid for by the consumer/employer (in case of corporate-funded programs) to a risk pooling entity/insurance company

Out-of-pocket spending

Constitutes a large and important source of health care financing in developing countries



In the absence of a strong social insurance scheme, and a mix of public and private health care, India has high out-of-pocket spend as a percentage of total health expenditure, supplemented with private health insurance. Health insurance in India can be classified into three types: government-sponsored schemes such as the Rashtriya Swasthya Bima Yojna (RSBY), group insurance (non-government business, typically taken by firms to cover their employees) and individual business.



Penetration and coverage

Public/Private

The Indian health insurance industry has seen significant growth since it was opened for foreign players in 2015. The sector (excluding personal accident) experienced an impressive CAGR of ~17% during FY2012-16[26] and is expected to grow at a CAGR of 20% by 2020[27].

The market is primarily dominated by public health insurance companies, which contributed 62% of the total health insurance premium collected in FY17[28]. However, the share of private health insurers and standalone health insurers (SAHIs) grew impressively during the same period.

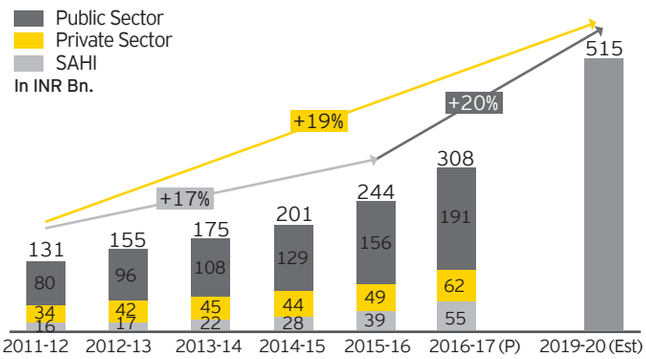
Group/Individual

Some of the key facts of health insurance coverage in India[29] are as follows:

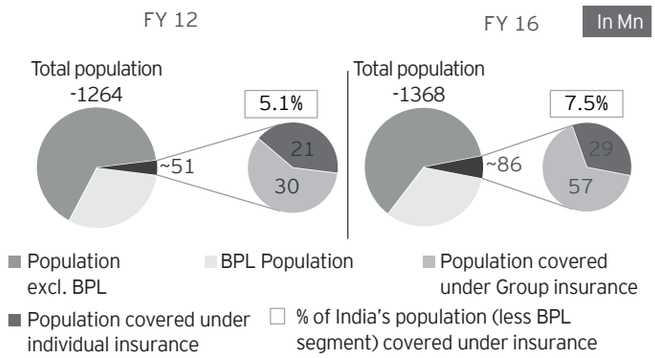
- 3,590 lakh lives were covered by health insurance in India as of FY16.
- Of this, a majority of lives were covered under government schemes, which included RSBY and other insurer-underwritten state schemes.

RSBY is a government-sponsored health insurance scheme targeted at the BPL segment, which is currently pegged at ~28% of India's population.

The penetration of health insurance among the non-BPL customer segment is very low at ~9.0%.



Health insurance premium



Health insurance coverage[29]

[26]IRDAI Annual Report FY16 Table I.51
[27]"India:Health insurance market forecast to grow at 20% p.a.," Asia Insurance Review, 10 February 2016
[28]IRDAI Annual Report FY16, Gross premium underwritten by non-life insurers within India (segment wise) up to March 2017 (Provisional & Unaudited)
[29]IRDAI Annual Report FY16 Table I.53 | "India's Poverty Profile Snapshot 2012," The World Bank, May 2016 | "Poverty and Shared Prosperity 2016 - Taking on Inequality," TheWorld Bank, 2016



Regulatory environment

The Insurance Regulatory and Development Authority of India (IRDAI) has been very supportive in terms of policy design and development in the insurance industry. One of its several reforms to enhance penetration of health insurance in the country was the increase in the foreign investment cap from 26% to 49% in 2016, which opened the industry to foreign players.

Some other significant measures that were introduced in the Health Insurance Regulations 2016 to strengthen the industry in India are as follows:

- The "Use and File" process for group insurance products was introduced, allowing group insurance policies to be more customizable according to the employee's requirements as compared to retail policies, which follow the "File and Use" process. An internal committee of the insurer approves the products and the insurer can market them without prior noting of the IRDAI.
- The 2016 regulations allow general and health insurers to test new products in the market as "pilot products" for up to a maximum of five years. After the five-year period, the product should be either converted into a regular product offered by the insurer or withdrawn completely from the market based on valid reasons. In cases of withdrawal, the insurer has to give the insured an option to migrate to another product subject to portability conditions.
- "Combi products" can be a mix of any life insurance cover offered by a life insurer and a health insurance cover offered by a general or health insurer. The previous regulations allowed only a term life insurance cover to be a part of combi products.
- The 2013 regulations restricted insurers from providing coverage for AYUSH treatment methods in case of benefit-based products. This restriction was removed in the 2016 regulations.
- Cumulative bonus could be offered only on indemnity-based health insurance policies and was restricted from benefit-based policies. These restrictions were removed in the 2016 regulations.
- Life insurance companies were restricted from offering indemnity-based health insurance products.
- The 2016 regulations have laid greater emphasis on standardization of the terms involved in the health insurance business and their definitions. For example, the definition of "group" under group policy coverage is now more clearly defined as having a minimum size of seven individuals.



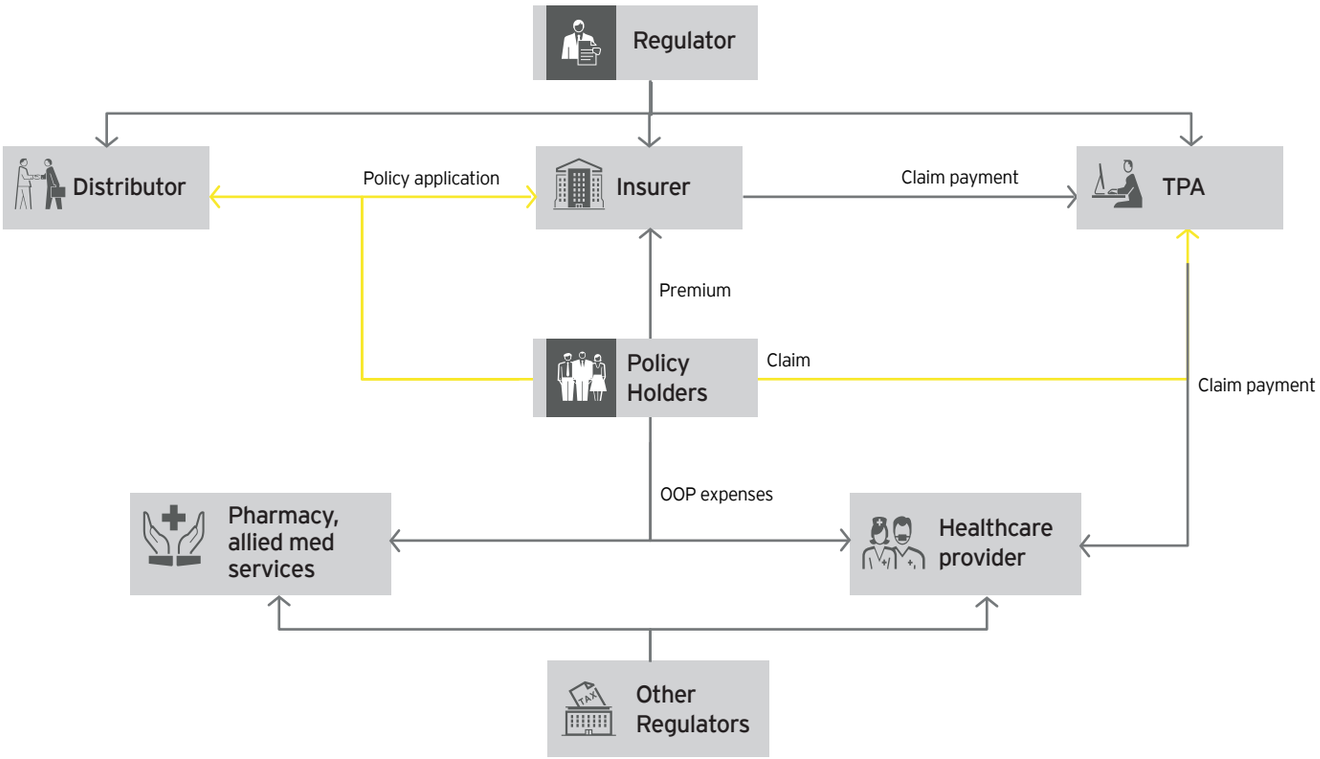
Health insurance market participants

The health insurance ecosystem consists of a number of players.

Policyholders buy insurance from insurers either directly or through one of the multiple distribution channels.

At the time of availing health care treatment, depending on the insurer and health care provider, the policyholder needs to make payments in one of two ways. For network hospitals and cashless plans, the insurer will make payments to the health care provider directly through a TPA. In other cases, the policyholder will need to make the complete payment and then claim reimbursement in line with the provisions of their policy.

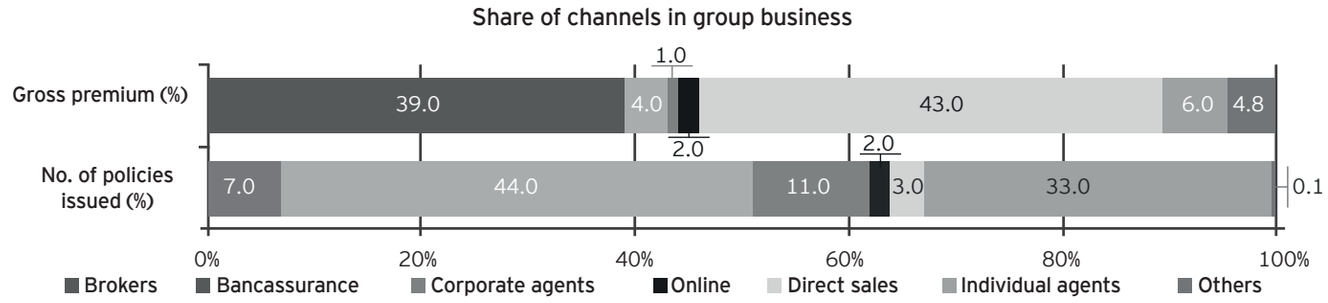
Spends on medicines and other allied services typically need to be borne by the policyholder unless incurred in the context of a covered hospitalization event.



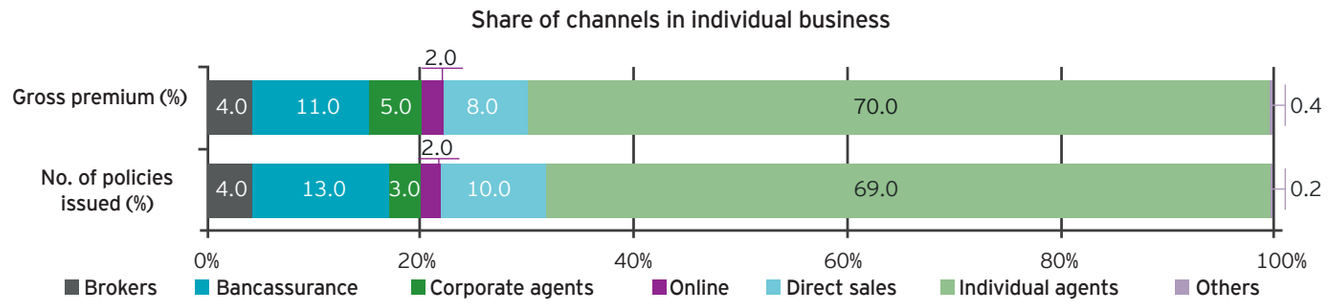


Distribution structure

Distribution plays a critical role in driving awareness, acceptance and sale of health insurance. Each of the channels has its own characteristics as well as benefits



Source: IRDAI Annual Report FY16 Table I.61



Source: IRDAI Annual Report FY16 Table I.61

Brokers

Insurance brokers serve as agents of customers, analyzing policies of multiple insurers to choose the best policy suited to their customers' needs. This channel works best for selling group insurance policies and expensive policies with higher premiums to affluent customers. As a result, it has a low share in policy volumes sold but a high contribution to net premium.

As an agent, the fiduciary responsibility and liability for mis-selling lie with the broker.

Insurance brokers can carry their business in any of these categories:



Direct broker

Operates between end-users or customers and private insurance companies selling insurance products directly to the consumers. The minimum capital required for an applicant to become a direct insurance broker is INR50 lakh. A direct broker can hold operations in life or general insurance or both.

Re-insurance broker

Assists private insurers in purchasing reinsurance from reinsurers. The minimum capital required for an applicant to become a re-insurance broker is INR200 lakh.

Composite broker

Acts as both a direct and a re-insurance broker. The minimum capital required for an applicant to become a composite insurance broker is INR250 lakh.

Individual agents

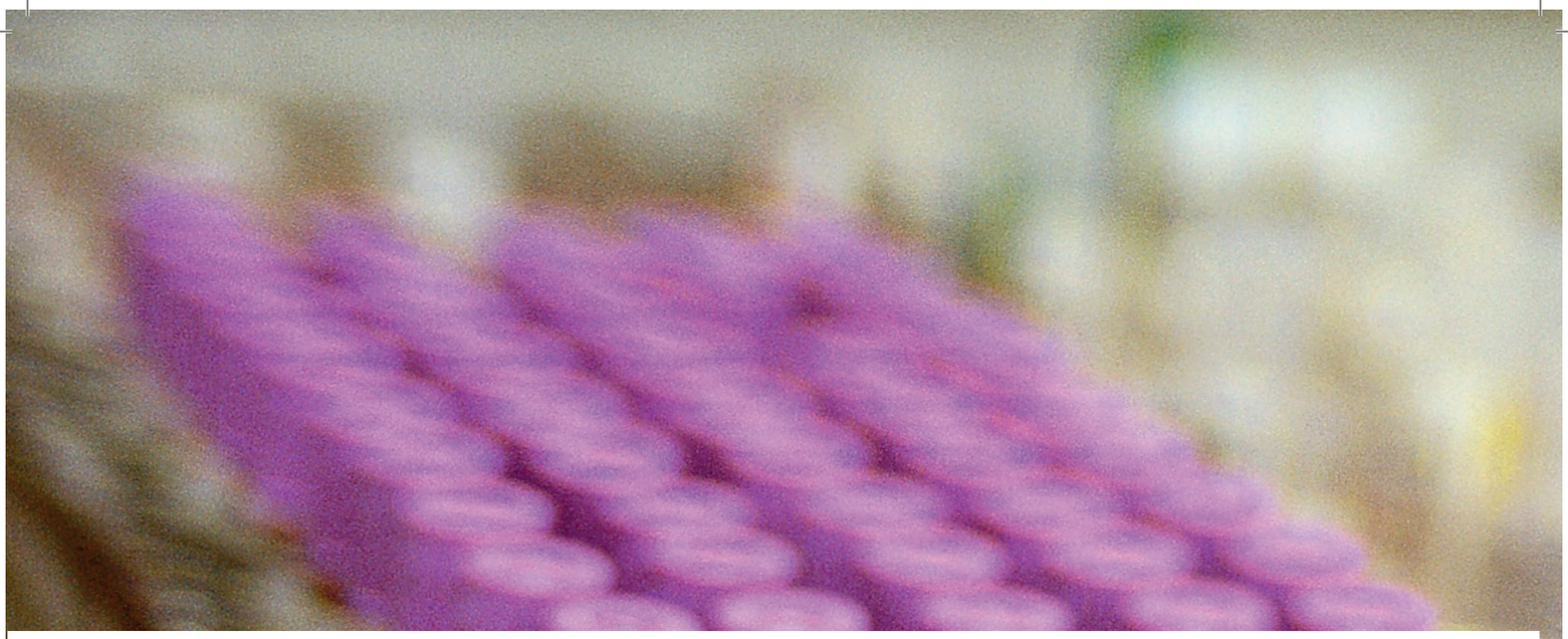
This is the primary channel for selling to individual consumers, has the deepest penetration and accounts for the largest share in terms of policy volumes sold. Individual agents are allowed to hold agency appointment for up to one life insurer, one general insurer, one health insurer and one each of the mono-line insurers.

Most agents in India tend to be relatively lower skilled or untrained or lack appropriate financial knowledge. Combined with the fact that a large proportion of their revenue comes from sourcing new policies, this channel is responsible for the largest share of complaints and issues relating to mis-selling.

Since they represent the insurance company, insurers are liable for any issues arising out of the agents actions. The regulator has undertaken a series of initiatives regarding training (licensing) and registration (centralized database, blacklisting etc.) to help enhance the effectiveness of the channel, the success of which is dependent on the trust and credibility that an agent is able to engender in a customer.

Corporate agents

Corporate agents are entities that represent an insurer and sell their insurance policies to customers. According to the latest IRDA regulations, corporate agents can represent a maximum of three life insurers, three non-life insurers (other than health) and three health insurers. In addition, they can represent the two specialized insurance companies, Export Credit Guarantee Corporation and Agriculture Insurance Corporation of India. Insurance companies are responsible for the mis-selling done by corporate agents.



Banks

Banks have emerged as one of the fastest growing distribution channels for insurance. Key drivers for growth include the existing customer base (bank customers) and understanding of the client's needs, allowing the bank to recommend the most appropriate product to the customer

Under "open architecture" norms, the IRDAI has allowed banks to sell products of up to three life, non-life and standalone health insurers[30]. To protect consumers and ensure competition, IRDAI has put a cap on business from a single client (not more than 50% of the premium shall emanate from any one client). This addresses the issues of the new market entrants who do not have any banking partners for their product distribution.

Direct sales

This involves insurance companies selling their policies directly to customers without the involvement of any intermediary. The direct channel caters majorly to the affluent sections of the society. This channel has a significant share in the premium collected from group insurance business.

Online channels

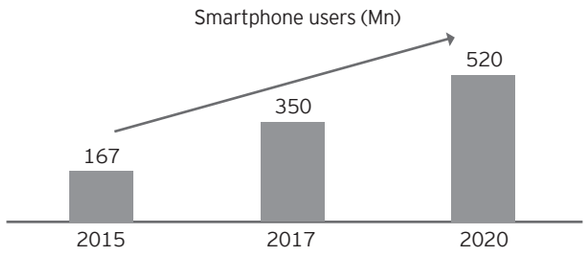
Online insurance distribution represents the channel of the future and is a key focus area for all insurers. It is driven by innovation and big data and allows consumers the ability to undertake quick, personalized and seamless policy comparison, purchase and renewals.

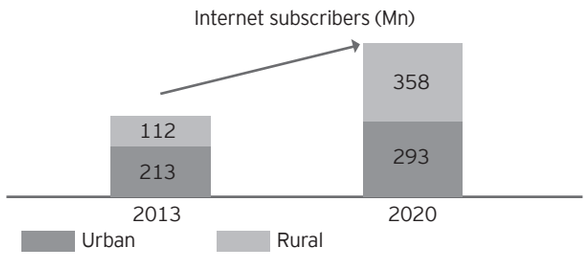
Internet penetration in the country is a huge enabler for increased distribution via this channel. India currently ranks second globally in terms of the number of internet users. The number of smartphone users and internet subscribers continues to increase rapidly.

Therefore, if the industry is able to utilize this channel efficiently, online insurance sales can emerge as the major driver for growth in the industry. The impact of this channel can be assessed by the fact that online purchase of health insurance policies has already exceeded that of life insurance, despite the relative disparity in penetration[31].

Data on Internet usage in India[32]:

- Internet users in India (2016): 462,124,989Mn
- Share of total population: 34.8% (penetration)
- Total population: 1,327,801,576 Mn
- Share of world Internet users: 13.5%





[30]"IRDAI allows banks to tie up with more than one insurer," DNA, 13 August 2015
[31]Understanding the Health Insurance market," Nielsen India, 2014
[32]"Number of internet users in the Asia Pacific region," Statista



4



Driving penetration in health insurance

Despite the need for health insurance and the significant investments in terms of regulations, establishment of stand-alone health insurers and products, penetration remains lower than desired. Even where health insurance is being sold, the cost of selling is impacting profitability.

1

Ethical selling

Life insurers now focus on ethical selling and advice in their ads.

Is health insurance industry lagging behind?

2

Cost

Cost of distribution is too high to allow small products to be viable- how to address that challenge, while being inclusive?

3

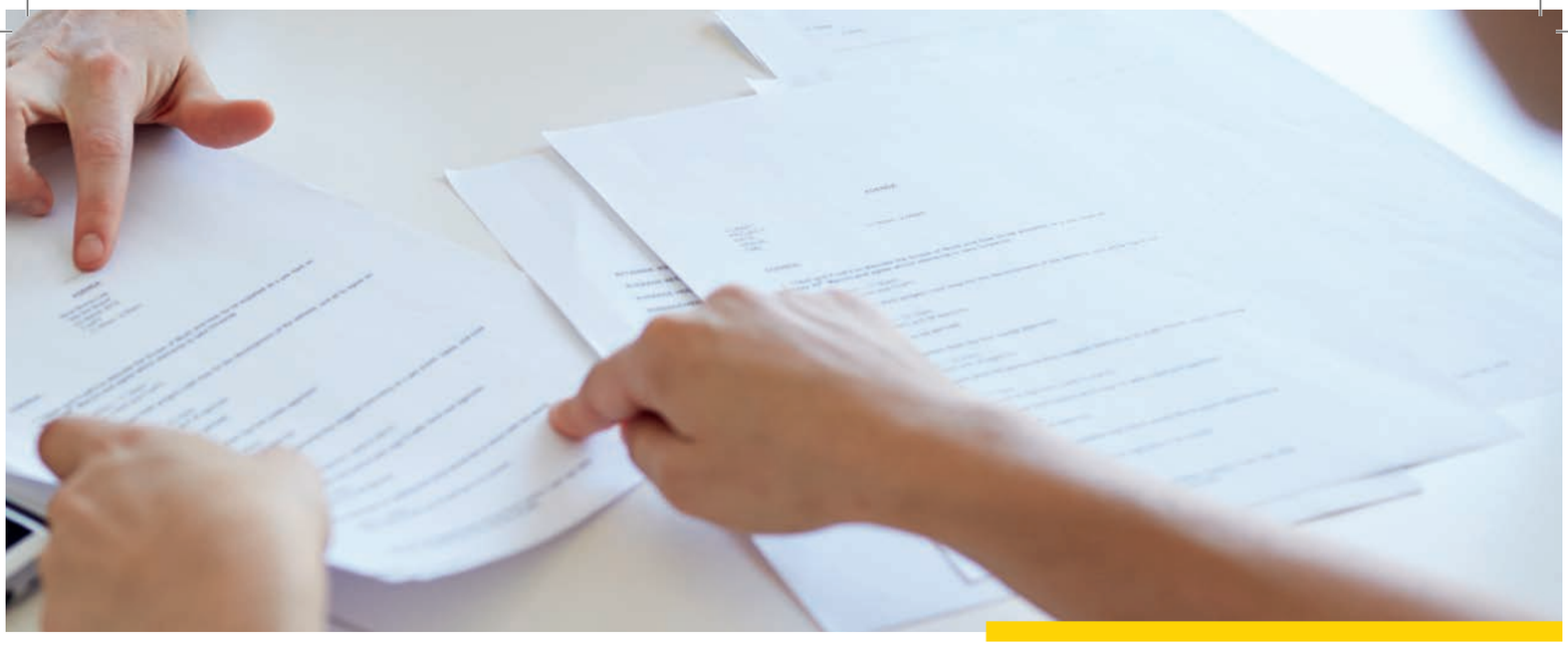
Technology

There are island of excellence in using technology for distribution, but other than online, other platforms are not scaling up

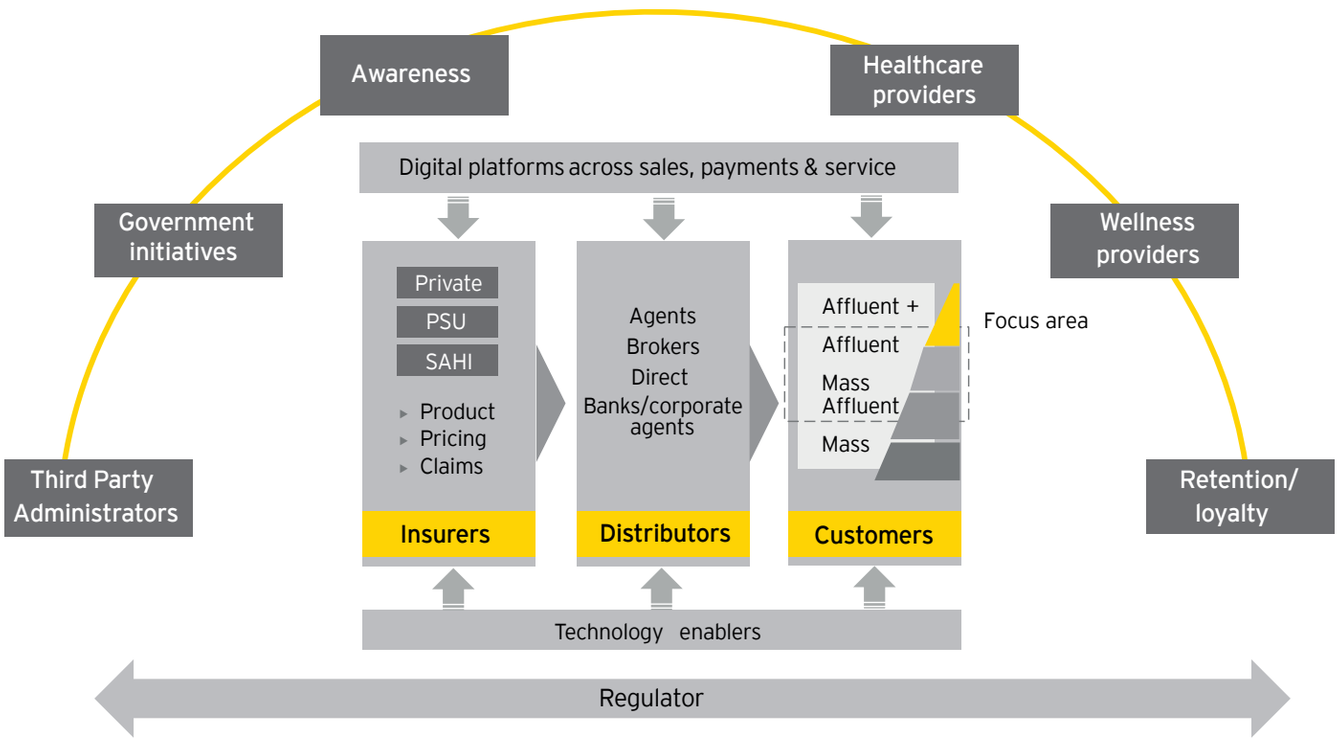
4

Penetration

What changes are needed in regulations to help the industry get to 40% sales growth for the next 5 years?



This paper identifies the key issues that impact distribution and penetration. Since India is a diverse country, with each socio-economic strata having different needs and concerns, the recommendations in this paper focus on the affluent and mass affluent segments of the society.



5



Prevailing challenges

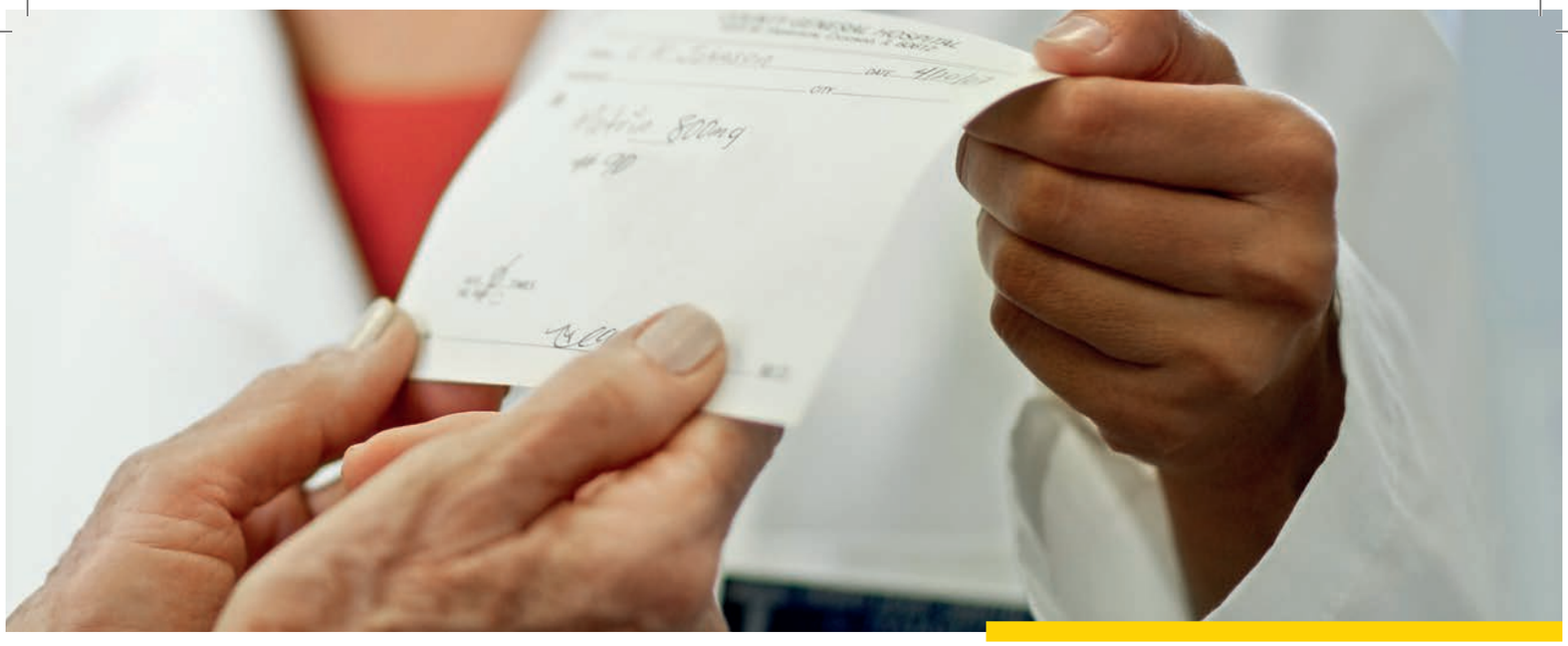
The last few years have seen a growth in the penetration of health insurance. However, all of the ecosystem participants still face challenges, some of which are shared below:

Customers

- Lack of understanding of health insurance terms such as "exclusions," "waiting periods," "room rent," "disease-specific payout limits" and "co-pay" is leading to customer dissatisfaction at the time of claim.
  - Customers usually do not see value in health insurance products as they do not see a return on investment as in money-back and savings plans in life insurance.
  - Health insurance is not viewed as a necessity but as an unwanted need or a tax-saving instrument.
  - People prefer to buy the health insurance after the diagnosis of a disease rather than as a protection tool.
  - Customers, especially younger customers, believe that they are "bulletproof."
  - 76% of the salaried youth in the age group of 23–35 view health insurance as a tax saving instrument and not as a necessity.
- Lack of outpatient cover: The absence/limited provision of out-patient treatment does not cater to a significant proportion of a customer's cost of medical care during the course of his or her lifetime.
  - There is a strong underlying belief that insurance companies do not settle claims.
  - Issues in claim settlement and fear of poor policy servicing lead to people preferring to keep their money in savings accounts for medical emergencies.
- The need for medicals is hindering the interest of the prospective customers.

Insurance companies

- Mis-selling and non-disclosure of the terms and conditions of a policy are hampering the image of the health insurance industry.
  - Allowance of portability for health plans, while designed to assist customers, has given a leeway to a section of unethical salespeople who intend to misguide customers to earn commissions, resulting in unnecessary porting.
- Critical illness rider, offered as part of life insurance, covers for critical illnesses, thereby partially reducing the need for health plans that cover critical illnesses, too.
- Though the lower income strata has huge business potential, the lack of profitability is hindering the penetration.
  - Lack of morbidity-related data of Indian customers leads to insurance companies taking a conservative approach to the designing and pricing of products.
- Delay in claim settlement and non-settlement of claims are major issues hampering the image of the industry.
  - According to Integrated Grievance Management System, the highest percentage of complaints among general insurance firms is for health insurance firms. The number of complaints rose from 10,000 in 2013–14 to 11,000 in 2014–15. The percentage of complaints on claim settlements is approximately 47%.
  - There have been numerous instances of regulatory bodies and consumers dispute redressal forums imposing fines on firms or upholding customers against unfair claim rejection and claim delay by insurance firms.



- Non-disclosure of medical information.
  - Concealing pre-existing disease (PED)/chronic ailment
  - Submission of fake documents to meet policy terms and conditions
  - Impersonation and providing duplicate and inflated bills
  - Staged accidents and fake disability claims
- Limited product flexibility.
  - Products largely converge around a "medi-claim" platform on an allopathic mode of treatment.
  - Given the evolving disease patterns, there is limited focus on creating new health insurance products for "modern' diseases."
  - Traditional forms of medicine such as Homeopathy, Unani and Ayurveda are covered to a limited extent.
  - Out-patient care, which constitutes a major part of a customer's spend, is not covered under a typical health insurance plans owing largely to a combination of the absence of morbidity data and a higher assumption of utilization.
- Lack of comprehensive morbidity data is hindering the design of cost-effective and innovative products, especially for the rural sector.

Third Party Administrators (TPAs)

- Lack of ownership by TPAs is leading to concerns around service.
  - Since TPAs work for multiple insurers, they may not exhibit a strong sense of ownership of the customer and claim, resulting in grievances.
  - TPAs have struggled in the past with poor quality of work, resulting in unnecessary queries and delayed settlement of claims.
- TPAs are ignoring small nursing homes due to complicated documentation and high fraudulent practices.
  - The processes are not standardized, leading to high costs of scrutiny and servicing.
  - Multiple documentation formats are followed by different hospitals.
  - Larger institutions have digitized processes while smaller ones follow manual processes.
- Significant effort is required to manage fraud, such as:
  - Fake billing for services not provided, overcharging and inflated billing
  - Unwarranted procedures, excessive investigations and expensive medicines
  - Extension of length of stay and overutilization
  - Patient history and record fudging



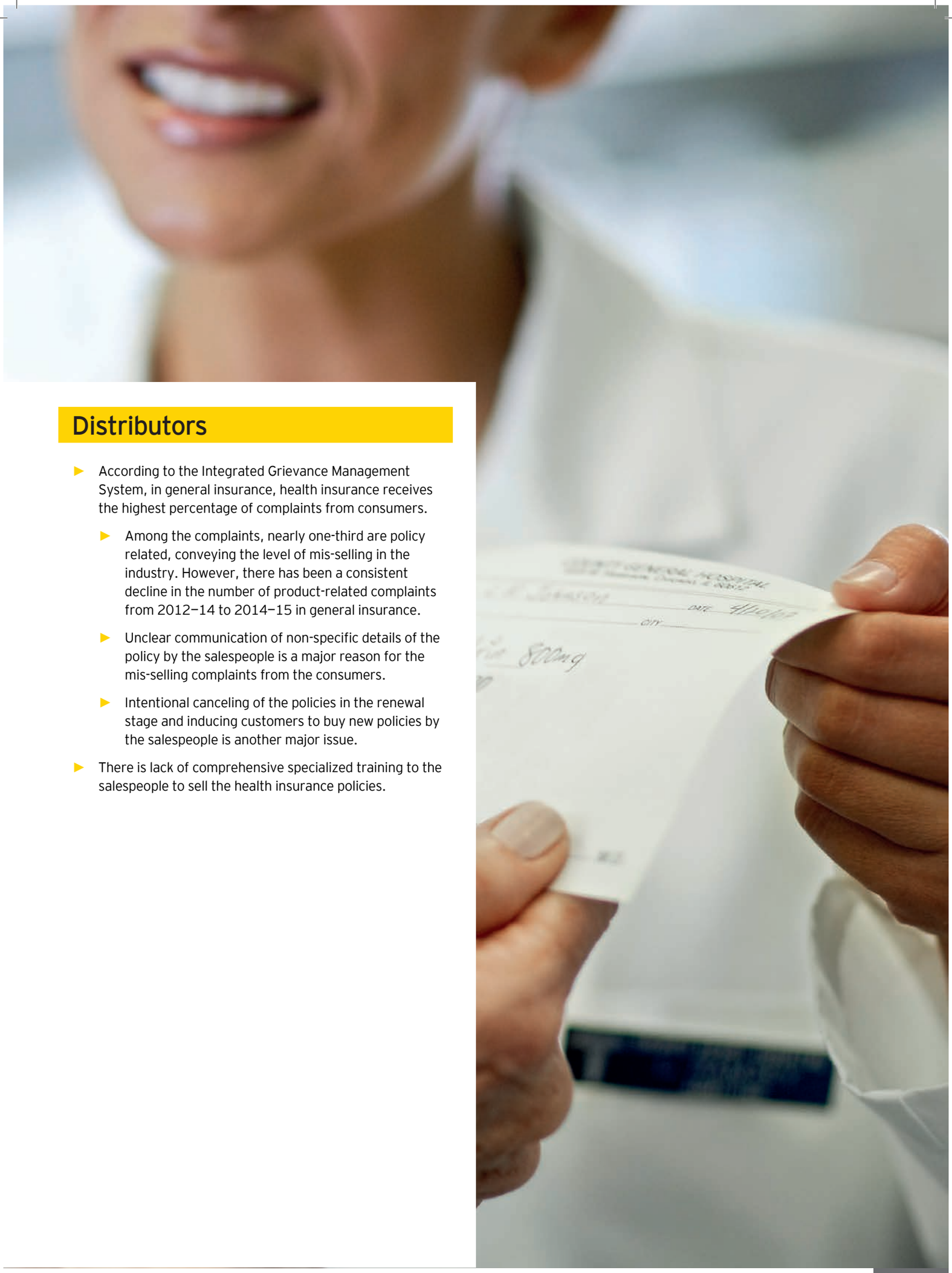
Regulator

- The Regulator has barred life insurance companies from distributing indemnity-based health insurance products across both individual and group platforms.
- While increased penetration is being emphasized on, life insurance companies, which have a greater penetration, are being deterred from participation.
- The lack of level playing field between non-life and life insurance companies is restricting life insurance companies from active participation in distributing health products.
- Section 45 of the Insurance Act is another deterrent making insurance companies overcautious of doing business in a geographical location with high fraudulent practices by organized rackets.

Hospitals and health care infrastructure

- The absence of a health care regulator means there is minimal control on health care providers.
- The pace of quality accreditation of health care providers is slow.
  - Though National Accreditation Board for Hospitals & Healthcare Providers (NABH) standards were implemented nine years ago in India, only ~400 hospitals are NABH accredited till now.
  - Smaller hospitals cannot get NABH certified due to the stringent regulations and costs involved.
  - There is a lack of awareness about the merits of the accreditation and ignorance toward the importance of quality in healthcare services.
- There is no regulation for mandatory registration of health care providers.
  - Currently, there is no mandate for healthcare providers to get registered, resulting in poor quality healthcare providers coming up all over the country.
  - Registration of health care providers is currently governed at the central level by the Clinical Establishments (Registration and Regulation) Act, 2010. Only Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim and all union territories have implemented the Act.
- Lack of standard treatment protocols for healthcare providers means that every healthcare provider follows its own internal guidelines, resulting in high degree of variance in treatment outcomes and cost of healthcare.
  - Non-utilization of International Classification of Diseases (ICD) codes by the hospitals: Unavailability or non-recognition of the ICD codes makes the standardization of the data difficult at the time of claim settlement.
  - The current information technology interface among health care providers, insurers and customers is not well integrated to provide seamless information transfer.
- The healthcare infrastructure in tier 2 and 3 cities and rural places is inadequate.
  - Health infrastructure is one major concern for the people in India, as the public spending on healthcare is dismal compared to developed and other emerging countries. The public spending on health care by India is ~1.4% of the GDP, while China spends 3.1% and the US spends 8.3%[33].
  - India has only 0.7 65 doctors per 1,000 patients, while WHO's minimum stipulation is a minimum of 1 doctor for 1,000 patients. While the WHO has stipulated 2.5 nurses for 1,000 patients, we have 1.74[34].
  - "India has only 1 bed for 1,050 patients, while the US has one bed for 350 patients and Japan has 1 bed for 85 patients[35].
- Low health care spending by the Government has led to high out-of-pocket spending from the people. India has one of the highest out-of-pocket spending in the world.

[33] "Health expenditure, public (% of GDP)," World Health Organization Global Health Expenditure database
[34] "A Universal Truth: No Health Without a Workforce," Third Global Forum on Human Resources for Health Report, November 2013
[35] "Mind The Gap: Health Workforce Shortage," the pioneer, 7 August 2017



Distributors

- According to the Integrated Grievance Management System, in general insurance, health insurance receives the highest percentage of complaints from consumers.
  - Among the complaints, nearly one-third are policy related, conveying the level of mis-selling in the industry. However, there has been a consistent decline in the number of product-related complaints from 2012–14 to 2014–15 in general insurance.
  - Unclear communication of non-specific details of the policy by the salespeople is a major reason for the mis-selling complaints from the consumers.
  - Intentional canceling of the policies in the renewal stage and inducing customers to buy new policies by the salespeople is another major issue.
- There is lack of comprehensive specialized training to the salespeople to sell the health insurance policies.

6



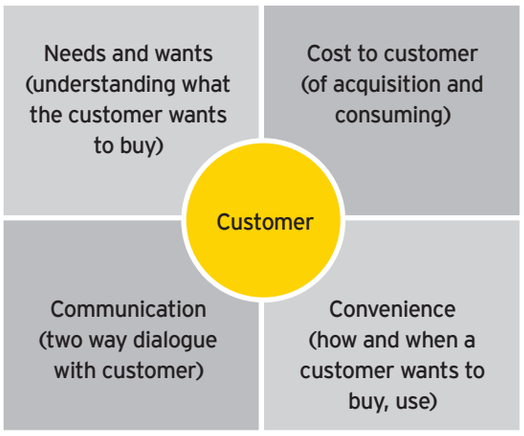
Addressing the challenges

We believe that addressing these challenges will require an understanding of their impact from a customer perspective, and accordingly designing solutions to address the impact. We have accordingly put the customer at the heart of our solution framework and classified the identified issues into a series of themes aligned to how the consumer interfaces with the industry and health care providers.

Challenge themes

The primary themes that have emerged from these discussions are as follows:

- Lack of consumer awareness of health insurance and the value that it provides
- Limited trust in the entire ecosystem
  - Insurers/Distributors providing the right product
  - Health care providers providing treatment at the right price
- Complexity of the purchase process
  - Comparing products
  - Taking a new policy
- High cost of insurance
  - Cost of management
  - Cost of servicing/renewal



Solution framework

Each of the issues identified above has a number of potential solutions and recommendations, which have been provided in the following section. For sustainable results, each of the ecosystem participants has a role to play:

- Regulator
  - Acting as an enabler in interfacing with other regulators and government bodies
  - Providing continued direction in addressing customer needs and protecting their rights
- Industry body
  - Enhancing awareness of health insurance
  - Engendering trust in the industry
- Insurer
  - Innovating products to address current and future needs
  - Providing benefits (and costs) that consumers see as "value for money"
- Health insurance distributor
  - Expanding outreach and awareness
- Health care and ancillary services provider
  - Supporting data standardization and reporting initiatives



1 Lack of consumer awareness and appreciation

Issue identified

Customers do not appreciate the need for health insurance. They are also not able to effectively assess the value that health insurance provides.

Recommended actions

1.1 Driving consumer awareness through campaigns

The regulator can independently run campaigns to increase awareness of health insurance and the value that it provides.

This can be supplemented by health insurance awareness campaigns run by industry associations. The funds available for this initiative can be boosted by linking such initiatives to CSR (subject to discussions with the appropriate regulators).

1.2 Enhancing visibility of existing awareness initiatives

The regulator runs a consumer education website which provides a lot of useful information. There is an opportunity to enhance the effectiveness of the website

- Enhancing the UX of the website
- Providing mobile and app versions of the site
- Increasing visibility as part of media campaigns

1.3 Enhancing student awareness through financial literacy

Another place where the regulator can play an enabling role in working with school boards and including a section in the curriculum on health insurance as part of basic financial literacy.

While the impact of such an initiative will take a long time to be felt, it will have the dual benefit of seeding knowledge with the next generation and getting them to disseminate it to their families.

Individual insurers have undertaken such initiatives in the past (e.g., spelling bee by HDFC), but a concerted effort by the industry players and industry bodies, in conjunction with a push by the regulator, is likely to be more effective.

Challenges in implementation

The regulator has a limited budget for advertising, which needs to be spread across all classes of insurance. There is no separate budget for health insurance or for the affluent/mass affluent categories.

Previous discussions with school boards to include insurance as part of the curriculum have not been as successful as desired.

Individual insurer initiatives are likely to focus on their own products and brands, taking away from the focus on growing awareness and education.

Other regulators might not be willing to allow awareness campaigns to be included as part of CSR spend.

Enabling roles

Insurance industry

Regulator



2 Complexity of the purchase process

Issue identified

While buying life insurance, health insurance riders are available for purchase.

In addition, general insurance companies and stand-alone health insurers have launched a large number of products with different exclusions, riders and top-ups.

Understanding which product to purchase is a daunting task for a consumer, and even using web aggregators or policy comparison sites does not substantially ease the process.

Recommended actions

2.1 Creating standard base products

The regulator needs to mandate standardization of base products for each product type:

- Standard minimum benefits (covers, nature of care, treatment type, minimum limits etc.)
- Standard terms and conditions
- Maximum exclusions and deductibles

The benefits can depend on the sum assured.

Insurers should have the ability to innovate by adding benefits or reducing exclusions.

However, insurers should be required to provide the base variant as well as enhanced versions.

This will allow consumers to compare products with ease. Providers will still be able to differentiate by providing additional benefits, convenience, exceptional customer service etc.

2.2 Making products easy to understand

The regulator needs to drive ease of comparison and understanding for consumers. Two areas that will have a major impact are:

- Clearly tagging base products (green) and products offering enhanced features (gold)
- Driving simpler language in product documentation. This refers not to merely standardizing the language but rather using simpler English/vernacular language content that a layman can understand and explain

Challenges in implementation

Standardizing and categorizing products will reduce flexibility and opportunities for differentiation for insurers. Insurers will be forced to compete largely on price and service.

Different customer segments (by income, age etc.) have different needs and a single product classification may be insufficient.

Given different operating models, strategies and target customer segments, getting insurers to agree on what needs to be included in each classification strategy may be challenging

Enabling roles

Regulator

Insurance industry association



3 Trust in the ecosystem

Issue identified

Consumers indicate, based on their experience and anecdotal information, that the price they pay for treatment differs based on the expressed mode of payment (self-pay or insurer pay).

Insurers and TPAs face issues with some health care providers with respect to inflated costs (unnecessary services, higher rates etc.), and information issues (insufficient information, inappropriate categorization etc.)

In addition, insurers also face high fraud claims in select areas, indicating the potential collusion by individual consumers.

Recommended actions

3.1 Rating ecosystem participants

The regulator has worked with the Indian Insurance Bureau (IIB) to create a database of hospitals across the country. A similar rating structure needs to be created encompassing health care providers (hospitals, nursing homes and independent doctors), associated services (physiotherapy, pharmacies and ambulance providers), third-party administrators and distributors (banks, brokers, corporate agents, individual agents etc.)

The data can be stored with IIB, which can provide a mechanism for data addition, retrieval and challenge. The data can be used to provide a scoring mechanism and should be available for insurers to view, similar to what CIBIL provides for financial scoring.

In addition, the entity being rated or scored should have the ability to view its scores and the inputs by insurers, and a challenge mechanism should allow it to dispute specific inputs into the score.

This will allow for other ecosystem players to price appropriately and take necessary actions, including a proactive control and review mechanism. The benefits include:

- A de facto industry trust index
- Ease of use for customers, allowing them to see who is trustworthy (insurer/distributor/health care provider)
- Ease of monitoring for insurer (on customer/biller)
- Ease for health care provider (where to provide cashless/ reimbursement mode)

Challenges in implementation

Investment will be required to create and host the infrastructure.

The parameters and scoring mechanism will need to be agreed with insurers as well as other market participants.

Since a number of these market participants come under different regulators, engagement with other regulators may be required to ensure that all participants get registered with the database and contribute data.

There will need to be a robust challenge mechanism with a neutral arbiter and care will need to be taken to ensure that the data is not used to deny coverage to customers.

Data security and privacy will need to be maintained to ensure that there is no misuse.

Enabling roles

IIB

Insurance industry

Regulator



4 Ease of management

Issue identified

Insurers get diagnosis and treatment data in non-standard formats, typically as hard copies or scans. While it serves the purpose a per claim basis to assess the claim, it is difficult to consolidate this data and utilize it for analytical and product development purposes.

This is a complex problem which impacts health insurance in a number of ways. Insurers need quality data to be able to develop and price products, and to monitor their usage. In addition, the need for high manual intervention in reviewing claims adds to the cost of delivery.

Recommended actions

4.1 Standardized health data

The regulator has already undertaken a number of initiatives in this regard, issuing a circular in March 2016 requiring a standardized discharge summary and a standard claim form for provider billing; however, the usage is limited.

Challenges in providing the data in this format range from unwillingness or inability of providers (due to lack of appropriate technology infrastructure) to the inability of insurers and TPAs to force usage (since access to health care cannot be blocked) and only a limited portion of a health care provider's income comes from insuranc e.

In addition, the Ministry of Health & Family Welfare issued a circular in December 2016 updating the standards for electronic health records (EHR).

This requires a multi-step solution starting with:

- Insurers working with the regulator to assess whether the EHR standards and standardized billing as required by IRDA are sufficient or there is a need for additional coding of treatments (LONIC/WHO-FIC)[36].
- After the agreement, the regulator can play an enabling role by notifying the requirements.
- Insurers will need to be responsible for tracking usage (directly, through TPAs) and providing inputs to the regulator for modification as required.

The benefits include

- Better analysis of health issues and treatment
- Better treatment as well as pricing analytics due to anonymized/aggregated

Challenges in implementation

All assured would need to be included, not just the primary assured.

Sharing of data will need to be allowed (temporary basis with consumer approval) for treatment, and for pricing on shifting insurers. This will require conforming to data security and privacy guidelines to ensure that there is no misuse or data leakage.

Enabling roles

Regulator

Individual insurance companies

[36]Logical Observation Identifiers Names and Codes (LOINC), WHO Family of International Classifications (WHOFIC) including ICD, ICF, ICHI, ICD-O. See "Notification of Electronic Health Record (EHR) Standards - 2016 for India" for further details



5 Shift to health care and prevention

Driving preventive health care

Health insurance as designed and sold in India is largely used to indemnify consumers for treatment on specific events. Since treatment on health care is largely out of pocket, preventive care is not undertaken, leading to larger expenditure on treatment.

Recommended actions

5.1 Health care cost management through "capitated benefits"

Insurers should have the ability to tie up with networks under the "capitated benefit" models where payouts to health care providers are pre-determined, while consumers have the ability to make as many visits as necessary or desired.

Consumers benefit by:

- Being able to visit doctors as many times as required
- Visiting either a GP or a specialist
- Getting appropriate treatment in a timely manner
- Reducing the likelihood of self-medication

Health care providers benefit by:

- Having minimum guaranteed income from insurers
- The enhanced scale of operations and patient inflow

Insurers benefit by:

- Aligning health care provider needs to the right treatment
- The shift of focus to preventive care rather than treatment
- Being able to build better quality data around causes and treatment

Challenges in implementation

- Acceptance in the health care industry
- Need for an enabling regulatory framework (section 64 VB may be an issue)
- Monitoring mechanism

Enabling roles

Regulator

Individual insurance companies



Next steps

This document has focused on the affluent and mass affluent segments of society and recommended solutions to their specific issues

1

BPL

- Has limited access to health care
- Requires significant governmental assistance

2

Above Poverty Line (Urban)

- Has access to health care opportunities
- Unable to access insurance or leverage available insurance for private health care

3

Above Poverty Line (Rural)

- Challenges relating to availability of health care
- Issues in getting access to health insurance given the limited distribution reach



Annexure[37]

Learning from other emerging markets

Latin America

Health insurance as designed and sold in India is largely used to Although insurance growth is relatively high in Latin America, most of the population is still uninsured. Insurance accounts for less than 3% of GDP in countries such as Mexico and Colombia. It is only moderately higher in Brazil and Chile.

Low penetration rates are a result of several factors. A large proportion of the population is low-income and unbanked, and not yet viable consumers of insurance products. While the middle class is growing, many of these potential customers are still accumulating household assets and do not see the value of insurance. Finally, distributing and selling products at an affordable price point has been challenging.

But all this is beginning to change. Indeed, almost half of insurers not currently serving the low-income market are planning to offer mass-market products, while 33% plan to offer micro-insurance, according to industry group the Microinsurance Network. Bancassurance is providing the greatest access to micro-insurance to date. As most insurance products are purchased through financial institutions, bringing people into the financial system is ultimately the key to increasing insurance penetration. At the same time, firms are developing third-party distribution models to connect with individuals who are neither financially nor digitally connected to the banking system. These include small brokers and banking correspondents.

These challenges have increased the cost of distribution in Latin America. As a result, insurers are now turning toward micro-insurance products for tapping into the low-income class while at the same time leveraging technology to provide cheap and personalized distribution to the middle-income groups. With nearly 70% population using mobile phones, the digital channel is being planned aggressively by most insurers in this region to acquire new customers and increase penetration.

Some of the steps taken by insurers in Latin America to overcome distribution challenges are mentioned below:

- Many insurers in this region are forming retail partnerships, for example, with supermarket chains, malls and petrol stations to reduce their distribution costs while effectively utilizing the vast customer base of these partnerships.
- Insurers in Latin America have also leveraged prominent events such as the 2014 FIFA World Cup and 2016 Olympic Games to increase the growth and awareness of health insurance in the region.
- After Chile's 2010 earthquake, insurance companies spread awareness about the importance of financial planning and boost insurance sales in health and life businesses.
- Technology is readily being used by insurers to tap into the mass market in a cost-effective way.
- Some insurers and brokers in the Latin America region have already adopted automated claims management systems to speed up claims processes for customers.
- Digital channels are being explored aggressively by insurers; however, cybercrime remains a major barrier in countries such as Brazil.
- Premiums have been rising steeply in the Latin America due to inflation, rising medical costs and increasingly high occurrences of claims.
- To make products affordable for the low-income class insurers and rural untapped markets, micro-insurance products are being released and distributed by insurers.
- Insurers are also focusing on developing a closer and more direct relationship with customers via customer engagement approaches to gain the trust of consumers.

[37]EY Latin American insurance outlook, 2017



Annexure

Learning from other emerging markets

Mexico

Health insurance as designed and sold in India is largely used to The instability in Mexico's financial and political environment has shrunk the purchasing power of consumers. As a result, the life insurance premiums saw a reduction in rates for two consecutive years before 2015. Although no significant change in rates has occurred for the health insurance sector, the profit margins have reduced. Mexican insurance companies have been trying to accommodate their losses and thinning profits by looking for cheaper alternative channels for selling their products. Medicall Home is a hotline-based health care advice and triage service in Mexico that has over 1 million subscribers. With a monthly fee of US$5, subscribers can avail services such as on-call consultations with qualified doctors 24x7 and request at-home doctor visits in serious conditions at a lower price, one free ambulance service, subsequent services at reduced tariffs and a host of other services.

Mexico's insurance space has healthy participation from all channels, including agency, bancassurance, direct channels and brokers, except microinsurance, which is still small.

Within life, agency has historically been the most popular distribution channel. It continued to be the largest channel in 2014, accounting for more than one-third of the total distribution space. However, the direct channel grew from 15% in 2009 to 31% in 2014. Bancassurance has become popular over the past decade, with banks either owning their own captive life insurance subsidiaries or selling insurance products. It accounted for 25% of life insurance volume. Within non-life, distribution is driven by the direct channel, brokers and agency. Bancassurance has been the fastest growing channel, with its share in gross premiums increasing from being negligible in 2009 to 8% in 2014.

Besides traditional channels, insurers are looking at alternate channels such as the Internet, mobile and even pharmacies to reach out to various customer segments.

Brazil

In recent years, the Brazilian economy (now the world's seventh largest in purchasing power) has been growing at a slower rate than during the pre-global financial crisis (GFC). Brazil's credit-fueled and consumption-based development model has reached a plateau, with inflation rising gradually. In addition, benchmark interest rates are at a 10-year record of 14.25%. At the same time, microeconomic interference, a weakening currency and subdued commodity prices have made the situation more challenging.

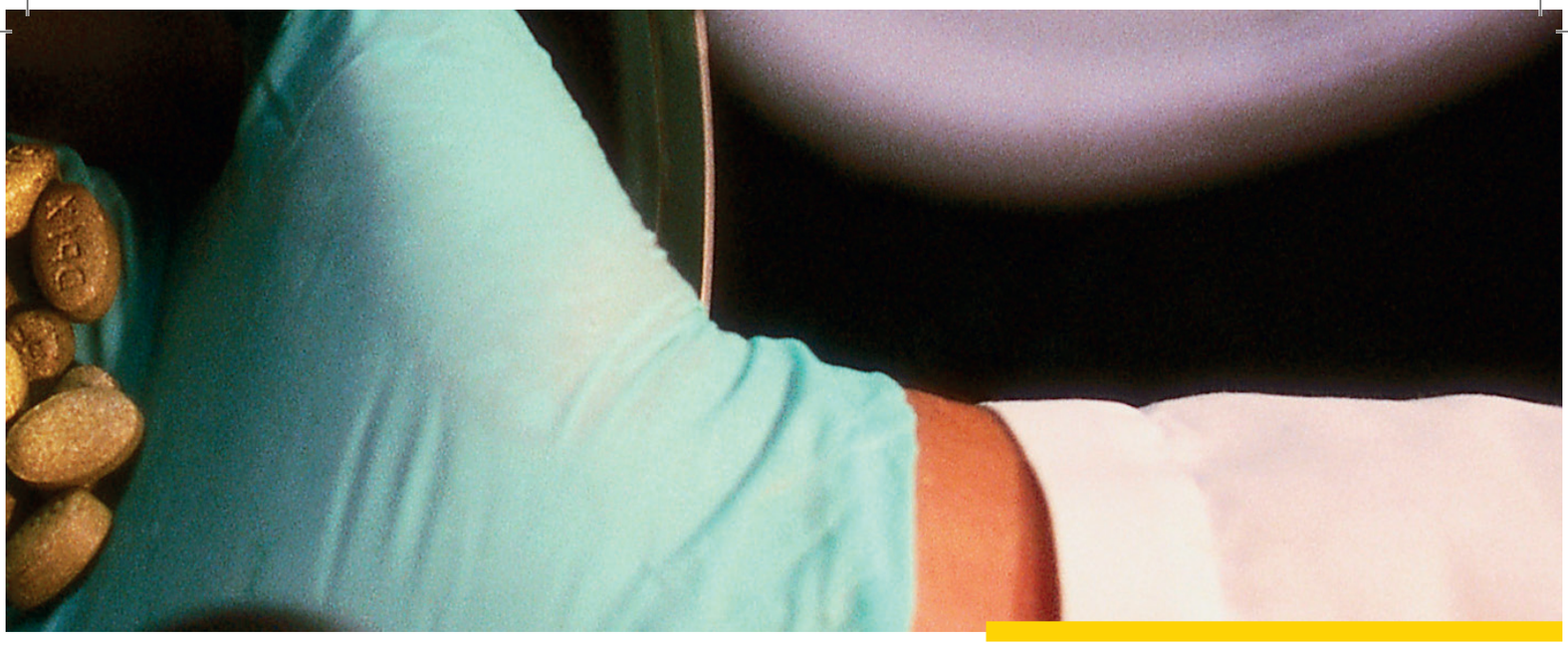
This mid-term crisis is creating strong pressures on the public pension and health systems. People are starting to realize that they need to have alternatives beyond the public welfare and that they need to complement their coverage with savings, pensions and health products provided by the private sector.

With several prominent insurers owned by large financial groups, bancassurance acts as a natural distribution avenue for insurance products as it provides access to the core mass market while helping banks to diversify from lending. Bancassurance holds approximately 80% market share in life and pensions products and approximately 15% in non-life products.

Large financial groups that own insurance companies benefit from this profitable environment. However, it is likely that customers will focus on better value for money as they mature and start considering new distribution options.

Most foreign insurance players are less profitable than large local bancassurance corporations. This disparity is due to the lack of bank tie-ups or suboptimal scale of their operations in Brazil.

In the non-life segment, independent brokers lead the market while bancassurance is less dominant.



Independent brokers dominate the segment since the regulator (SUSEP) mandates having a broker as an intermediary. Affinity models are growing and are likely to continue to do so, as some players have successfully entered agreements with large retailers and partnered with the lottery network, particularly for specific products, such as extended warranties. Over the medium term, we expect banks to remain the primary channel of distribution, while brokers will likely see a gradual drop in their market share and new channels such as digital will become increasingly important.

With high mobile and internet penetration in Brazil, 139% and 58% respectively, all sectors have become interested in the digital space. Insurance is no exception, with all big players investing in digital and direct.

Digital and direct initiatives by insurers in the Brazilian market are still emerging and focus primarily on innovation in sales channels especially at the quotation stage. While some players offer online quotations and sales, other players only offer online quotations. However, most players do not have an app specifically for insurance. There are approximately 10 insurance apps in Brazil including a few for auto insurance and health monitoring.

While digital is still a niche for insurers, robust digital operations are likely to emerge in the next four to five years. It is expected that digital will disrupt not only the distribution channel in insurance but also the existing operating models owing to significant cost and operational advantages.

Africa

Health insurance as designed and sold in India is largely used to Africa, just like Latin America, has a huge chunk of uninsured population, but in contrast it has very poor communication and technology penetration, hence digital disruption and the use of technology for insurance distribution are rendered ineffective in this region. More than 60% of the population lives in rural areas, which means even the traditional channels of distribution are ineffective in acquiring new customers. Some ways in which the insurers in Africa are improving insurance penetration are stated below:

Insurers are partnering with NGOs, farmers' cooperatives, commodity trading companies and rural associations or opening up microfinance institutions to sell micro-insurance products to the rural population.

Because the population is mainly from the low-income category, some African insurance companies have even started selling health insurance policies by partnering with roadside shops, groceries and supermarkets as these distribution channels are usually inexpensive and more frequented by the populace than conventional distribution channels.

In some places, churches were used to spread awareness regarding the importance of health insurance. The persuasive power of the institution was a key driver in convincing believers of the importance of health and financial planning for health care expenses.

African nations have seen a significant increase in mobile usage, although Internet penetration remains low. Hence, insurers have initiated partnerships with telecom service providers to take advantage of the increasing usage of mobiles and spread awareness and facilitate distribution via calls and messages.

Some insurance companies have developed "low premium, low benefit" products to attract the rural, low-income population in Africa. Premiums can be as low as US$5 annually and benefits can be as simple as consultations with expert doctors regarding symptoms, medicines and diagnosis. This is also beneficial to the insured as specialist or expert doctors might not be available in such rural areas.



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