Expanding Health Coverage through Community Based Health Insurance

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1. Introduction

Health financing is an important component of any healthcare system. In India, financing for healthcare continues to be characterized by low budgetary allocation by governments and high out of pocket expenditures (OOPE) for individuals and households. While the poorest and the most vulnerable sections of the population are the focus of tax financed schemes such as Pradhan Mantri-Jan Arogya Yojana (PM-JAY), the other end of the economic spectrum occupied by the well to do households have access to health insurance products offered by commercial health insurers. For those in formal employment, schemes such as Employees' State Insurance Scheme (ESIS) and employer provided group insurance schemes offer healthcare coverage. This leaves informal sector workers and those who are self-employed, and without access to government provided health insurance, unprotected from catastrophic healthcare expenditure. Besides, all insurance products offered by commercial health insurers cover only hospitalization, with no links to basic primary and outpatient healthcare services (Bhat et al., 2017).

In the case of government provided health insurance, resource constraints and lack of infrastructure and organisational capacity that can ensure enrolments, collection of contributions, processing of re-imbursements, and effective monitoring of health and financial outcomes are often cited as reasons for their inability to organize healthcare at a national level (Carrin et al., 2005). On the other hand, profitability and ease of onboarding clients are some of the considerations which have limited the focus of commercial health insurance market in India to the more affluent and urban sections of the population (IRDAI, 2020). This has resulted in a one-size fits all approach where the products are either unsuitable to the needs of the low- and middle-income populations or are out of their financial reach (Dror, 2008). While microinsurance products of commercial health insurers are expected to fill this gap, their performance measured in terms of penetration levels remains low. However, these products are viewed as economic instruments with the potential to alleviate poverty by reducing the OOPE incurred by vulnerable sections of the population in accessing healthcare services (IRDAI, 2020).

Hence, until a Universal Health Coverage (UHC) model can effectively meet the healthcare needs of all sections of the population, insurance offered through private or other non-governmental mechanisms are two options that can be potentially explored. In this context, given their accessibility and reach, Community Based Health Insurance is seen as one such mechanism which can overcome some of the barriers discussed above and improve access to healthcare and financial protection for vulnerable low- and middle-income populations.

2. Community Based Health Insurance

The term Community Based Health Insurance (CBHI) is used to refer a wide range of resource pooling mechanisms organized at the level of the community for provision of healthcare services. It includes mechanisms such as microinsurance, mutual health organisations, and revolving drug funds (Carrin et al., 2005; Jakab and Krishnan, 2004). While the organisation, management, and institutional characteristics can vary from one CBHI to the other (Jakab and Krishnan, 2004), community involvement in the operations of the scheme, its non-profit nature, use of basic principles of risk sharing, and reliance on the ethic of solidarity or mutual aid are the key features which distinguish

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CBHI from government and for-profit commercial health insurance (Carrin et al., 2005; Donfouet and Mahieu, 2012; Jakab and Krishnan, 2004).

Community, in the context of CBHI, can be defined as a "group of households living in close proximity to each other, such as a village or a neighborhood. Often for risk pooling and managerial purposes, the villages might be grouped. A community can also be a group of people formally organized to advance some common interest (for example, agricultural and consumer cooperatives)" (Hsiao, 2004). CBHI, therefore, offers the potential to reach low- and middle-income populations through existing community-based organisations (CBOs) such as non-government organisations (NGOs), self-help groups (SHGs), cooperatives, micro-finance institutions (MFIs), and trade unions (Bhat et al., 2017). Regardless of the type of CBO through which CBHI is offered, social capital has been found to be a key determinant of demand or the willingness of communities to enroll in CBHI schemes, pay for the services offered, and cooperate with each other (Donfouet and Mahieu, 2012; Ko et. al, 2018; Preker et al., 2004).

Social capital can be defined as "networks together with shared norms, values, and understandings that facilitate cooperation within and among groups" (Bhat et al., 2017). It indicates the degree of social cohesion and solidarity present within a community, or in other words, mutual concern that members of a community have for each other. This becomes important for CBHI as it involves payment of contributions to a scheme which uses the financial resources to spread risk across all members within a community – rich and poor or healthy and sick. This essentially translates to the willingness of the members of a community to participate in a CBHI when the level of benefit an individual or a household can expect from the scheme vis-à-vis their contribution is unknown (Preker et al., 2004). The presence/ absence of social capital or the degree of social capital within a community has been found to be linked to the success or failure of CBHIs and its long-term sustainability (Donfouet and Mahieu, 2012; Ko et. al, 2017; Preker et al., 2004).

In addition to social capital, other factors that have been attributed to increased willingness of communities to enroll and participate in CBHIs include:

a. Trust in CBOs - Communities intended to be covered through CBHIs have been found to have greater trust (with higher likelihood) in health insurance offered by CBOs as compared to national programs. The latter have been found to be viewed by communities as being unfavourable on account of their inability to deliver or meet their needs. On the other hand, communities are already members of CBOs and there is an element of familiarity with the operations of CBOs as well as with their personnel. This is also reinforced by a sense of ownership the community gains from participating in various activities of CBHI (Preker et al., 2004).
b. Responsiveness - A governance structure which is responsiveness to the needs and preferences of the community has been found to be another factor key to the success of CBHIs. This is facilitated not just on account of the community's participation in the operations of the CBHI, but also on account of proximity to the members of the community (Bhat et al., 2017; Carrin et al., 2005).
c. Need based approach - CBHIs offer the scope to design health insurance based on the needs of the community by taking into account local health priorities and the ability of communities to pay for insurance. This can translate into premiums, benefits, and claims that are relevant, attractive, and affordable. This is again facilitated on account of proximity to the community, participation of the community in designing CBHI, and more importantly, a CBO's knowledge

about the needs and other socio-economic characteristics of the community (Bhat et al., 2017; Mathauer et al., 2017).

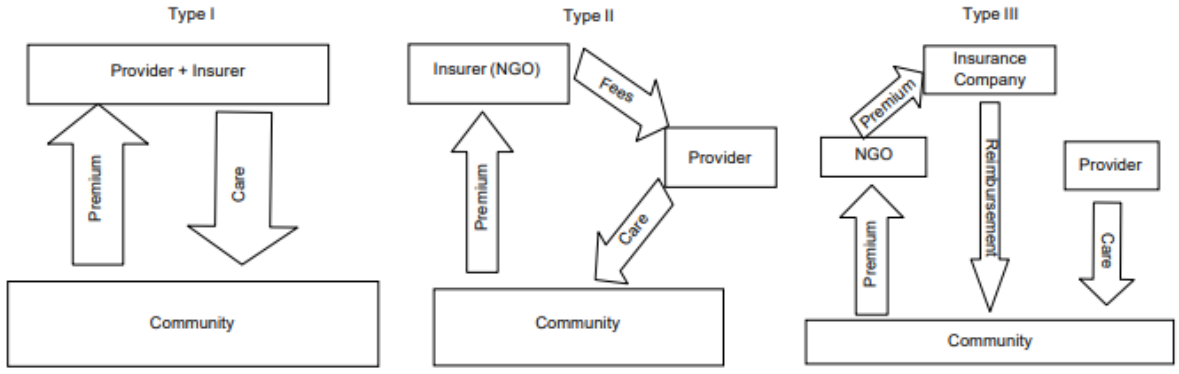
3. CBHI Models in India

Given the sections of the population they are intended to serve, affordability is a key consideration and CBHIs generally offer microinsurance products which are characterized by low premiums and limited health cover (see Table 1). The Insurance Regulatory and Development Authority of India (IRDAI) recognized microinsurance as a separate product category in the year 2005 with the objective of improving insurance penetration among economically vulnerable sections of the population. In addition to for-profit insurance intermediaries such as individual agents/ brokers and corporate agents, micro-health insurance products are also distributed by CBOs through CBHI schemes in India.

Depending on who the insurer is, there are broadly three models of CBHI through which such products are offered (see Figure 1 and Table 1) -

a. In Type I model, the healthcare provider plays the dual role of both providing healthcare services as well as running the insurance programme. These are essentially Health Maintenance Organisation (HMO) type schemes in which members pay premiums to the provider and are in return entitled to outpatient and inpatient services without any additional charge or at discounted rates.
b. In Type II model, an NGO acts as the insurer and contracts with providers for offering healthcare services. Members enrolled in this type of scheme pay premiums to the NGO and are in return reimbursed for the expenses incurred by them in availing services from a pre-defined provider network. This is also referred to as the mutual model where the risk involved in providing insurance cover is retained by the NGO.
c. In Type III model, the NGO acts as an intermediary/ agent of an insurer. These are akin to the typical partner-agent model where the insurer develops the insurance products and underwrites the risk, and the agent, in this case the NGO, is responsible for selling, distributing, and servicing the products. Some CBHIs use a combination of Type 2 and Type 3 models to service the needs of a target population.

Figure 1: Types of Community Based Health Insurance in India



Source: Devadasan et al., 2004

In all three models, members of the community participate in various activities of the CBHIs to varying degrees, including designing the scheme, collection of premiums, and claims management.

Table 1: Key Features of Select CBHIs in India

Key Features	Uplift	Annapurna	VimoSEWA	Shepherd	SKDRDP
CBHI Model	Mutual model	Mutual model	Master policy-holder, partner-agent, and mutual model	Partner-agent and mutual model	Partner-agent
Location/districts covered	Mumbai, Pune, and tribal villages in Rajasthan	Mumbai and Pune	Gujarat, Madhya Pradesh, Bihar, Rajasthan, and Delhi with 20 partner organizations	Tamil Nadu (10 districts)	Karnataka
Max limit	8 cashless in-house OPD and IPD floater of Rs 12,000	Rs 40,000 for health	Health – Rs 25,000 Mutual hospicash - Rs 3,000	Health – Rs 10,000 Hospitalisation due to road accident – Rs 50,000	Health - Rs 1 lakh
Claim time	24 hours	45 days Post-Covid - 24 hours	Mutual product - 5-8 days Other products - 25-45 days	60 days	75 days
Scale	20,608 members in 2019	2.52 lakh clients at start of 2020	84,000 members as on December 31, 2019	40,000 members as on December 31, 2019	87.12 lakh members in 2019

Source: Report of the Committee on the Standalone Microinsurance Company, IRDAI, 2020

While Type III, the partner-agent model is recognized by IRDAI, Type I and Type II are not legal CBHI models as microinsurance distributors are not allowed to design and underwrite insurance products. Under Type III, IRDAI's microinsurance regulations allow a host of intermediaries, including NGOs, SHGs, MFIs, and cooperative societies to distribute microinsurance products as agents of commercial insurers (IRDAI, 2015) . In return, they are entitled to commissions which are paid as a percentage of premium of the insurance sold by them. However, as IRDAI's Report of the Committee on Standalone Microinsurance Company, 2020 (SAMI Report) observes, the share of microinsurance business distributed in this manner to the total insurance business continues to remain extremely low. The report identified six major issues which are acting as barriers to expansion of microinsurance by existing insurance companies. These include lack of trust in large commercial insurers, high transaction costs in serving regions where the target population resides, absence of need-based products, delays in claim settlement, lack of long-term business perspective among large insurers in relation to microinsurance, and general lack of awareness about the utility of insurance products among low and middle-income population.

The provider-insurer model and the mutual model of CBHI can overcome some of these barriers posed by the partner-agent model. They offer the potential to meet the needs of the communities in a more effective manner through -

a. Health seeking behaviour – Partner-agent model relies on indemnity-based insurance where the use of healthcare services is dependent on the health seeking behaviour operating at an individual level. On the other hand, the mutual model encourages a community-based approach by leveraging the social capital present in the community to mitigate the effects of

individual behavioural biases. In Type I model, where the provider is the insurer as well, the health seeking behaviour of the community is largely influenced by the providers.

b. Health insurance awareness – Unlike partner-agent model which tends to have a narrow focus on the process of sale, under mutual model, the activity of selling is part of a wider process of empowering the community and educating them about the benefits of health insurance. In provider-insurer model, the awareness levels are high as the insurance is known through the healthcare provider.
c. Healthcare offered – Under partner-agent model, indemnity-based health insurance products which are generally standard offerings of large insurance companies are sold to communities. These come with limited customization and focus mostly on hospitalization. Under mutual model, participation of the communities is central to the design and development of CBHIs. Additionally, many health mutuals take a holistic approach to healthcare by focusing on preventive and promotive care in addition to curative care. The provider-insurer model may provide holistic package of services, as there are no incentives to increase hospitalization incidences. However, the community does not have option to choose across providers of care, which is possible under the other two models.
d. Pricing – Standard micro-health insurance products offered by large insurance companies can prove to be unaffordable to certain communities. Here, the mutual model provides the scope for developing CBHIs which keep in mind affordability of the specific communities intended to be served. Additionally, health mutuals are able to keep their premiums lower on account of in-house claim management system along with in-built incentives to use low-cost facilities (Bhat et al., 2017).

As discussed in Section 2, trust in CBOs can help CBHIs mitigate the lack of trust poorer communities have in large insurance companies. On the issue of delays in claim settlement, SAMI Report observes that mutuals, which have their own health insurance products, are generally able to settle claims faster than CBOs which act as agents of insurance companies (also see Table 1).

4. CBHI through a Health Financing Lens

The choice of health financing method not only determines the availability of necessary funds, but also determines how effectively the healthcare system enables access to healthcare services to its population. The latter is sought to be achieved through a careful design of incentives facing providers. At a conceptual level, health financing system is generally divided into three sub-functions – (a) revenue collection, (b) pooling, and (c) purchasing/ provision of services (WHO, 2010). Hence, viewed closely, a health financing method also determines the type of entity/ person responsible for discharging each of these sub-functions – government ministries/ private entities/ community organizations, each with its own capacity, strengths, and weaknesses (Hsiao, 2007).

In this section, we breakdown the operation of CBHI using a health financing lens and identify the actors and mechanisms enabling the functioning of the model. We also discuss the specific implications it has on the two important objectives of ensuring financial protection and improved health outcomes for the target population.

4.1 Revenue Collection

Revenue collection is the process by which a healthcare system determines and mobilizes the necessary funds (WHO, 2000). The level of revenues collected determines the range of healthcare services the system can afford and make available to a population. Higher the revenue, lower the OOPE for the members of a CBHI in seeking healthcare. This effect can be more pronounced for the

poorer members of a CBHI, as low levels of revenue can translate into high OOPE on account of exclusion of certain healthcare services or inclusion of co-payment terms which can prove catastrophic on their finances (Carrin et al., 2005).

CBHIs generally raise funds through a combination of sources including pre-paid contributions, user fees, donations, and government subsidies. However, the main source of revenue remains pre-paid contributions from members of a community who wish to avail the healthcare services offered through the CBHI (Jakab and Krishnan, 2004). The contribution rates or the premiums are usually flat, also referred to as "community rated premiums". This means that at an individual member level, the rates are generally not linked to their incomes and can often be regressive, leading to exclusion of poorer members of a community (Mathauer et al., 2017). Matching the timing of premium collections with income patterns of a community has also been found to have a positive impact on the ability of CBHIs to raise revenues (Carrin et al., 2005; Jakab and Krishnan, 2004).

As discussed in sections 1 and 2, overall low-premium rates in CBHI are necessary to keep health insurance affordable and to consequently attract more members of a community to enroll. However, the final premium rates should also take into consideration actuarial calculations which are linked to the health risks posed by the members of the CBHI to ensure that the premiums are not too low, putting sustainability of the CBHI into question (Ranson, 2003). Here, availability of actuarial experts who can help determine such premium rates for small CBHIs has been observed to be a challenge. Regardless of how the premiums are determined, low-premium rates coupled with small pool size of CBHIs mean that the overall revenues of the scheme can remain small. While raising community rated premiums is an option to increase the overall attractiveness of the scheme in terms of financial protection and healthcare services offered, such a move can lead to further exclusion as more members of the community might not be able to afford the premiums (Mathauer et al., 2017).

4.2 Pooling

The objective of pooling, also known as the "insurance function", is to ensure that the financial risks associated with seeking healthcare are spread across all members of a pool and are not borne on an individual basis (WHO, 2000). The ability of CBHIs to achieve the required level of pooling is often constrained by the size of its membership, which generally tends to be small. A key concern here is the general voluntary nature of CBHIs, which also makes the model prone to adverse selection. Members of a target community who are at low health risk would prefer not to join the CBHI pool and this is exacerbated by the community rated premiums which are not linked to the health risk posed by a member. In other words, those who are at high health risks would end up concentrating the pool, making the CBHI financially unsustainable in the long term on account of high claims ratio (Carrin et al., 2005; Jakab and Krishnan, 2004; Mathauer et al., 2017). Additionally, since CBHI pools are small, they tend to be homogenous making risk diversification challenging.

CBHIs around the world and in India have used various mechanisms to overcome the issue of adverse selection. These include making membership mandatory, incentivising, in the form of lower premiums, an entire household to join the pool, and placing waiting time between enrollment and eligibility for benefits (Jakab and Krishnan, 2004). Hub & Spoke model is another alternative that CBHIs can employ. Under this model a part of the risk from the CBHI pool is transferred to direct insurers or reinsurers on a cooperative basis for better sharing of risk (Carrin et al., 2005; IRDAI, 2020). Other alternative mechanisms include formal arrangements for risk-adjustment or equalization mechanisms where CBHIs that face lower than average risks would undertake financial transfers to CBHIs that face more than average risks (Carrin et al., 2005).

On the issue of size of CBHI pools, as discussed in Section 2, social capital plays a key role in determining the willingness of the members of a community to enroll in a CBHI. Lack of social capital means that the size of the pool can remain limited. Here, integrating with other CBHIs forming a network of CBHIs can help increase the size of the pool and diversify the risks (Carrin et al., 2005). However, the small size of the pool also comes from the need to retain social capital as well as its core character of maintaining a close relationship with the communities (Bhat et al., 2017). This has downside implications as it restricts the level of pooling and access to a wider range of healthcare services, while also depriving the members of the community from cross-subsidies in premiums that can accrue from integrating with higher income groups (Preker et al., 2004).

4.3 Purchasing/ Provision of Services

Purchasing is the process by which the funds of a healthcare system are allocated to the providers in return for providing a set of healthcare services to its beneficiaries. Apart from making payments based on pre-determined budgets, purchasing can also be done by actively choosing providers and healthcare interventions that improve efficiency, also known as "strategic purchasing" (WHO, 2000). The process of purchasing determines the range of healthcare services that are offered to the members as well the provider network through which the same is made available.

In the case of CBHIs, their ability to include a wide range of healthcare services in their benefit packages is limited by the low levels of revenue they are generally able to collect. This also limits their ability to negotiate or bargain for preferential rates. Consequently, the extent and the size of the cover remains modest with limited financial protection, especially for high-cost services (Mathauer et al., 2017) (see Table 1). Given low levels of revenue, controlling for costs, especially those associated with overuse of healthcare services becomes important. CBHIs have employed a variety of mechanisms to address the issue of cost, including those arising from moral hazard and induced demand from the provider end. These include use of referrals for gate keeping, higher claim reimbursements for use of low-cost facilities, screening of each claim at a meeting which includes representatives from the community, and provision of value-added services which contribute towards overall improvement in the health status of the community (Carrin et al., 2005; Jakab and Krishnan, 2004; Ruchismita et al., 2013)

5. Challenges and Way Forward

Studies which look at the potential of CBHIs in contributing to effective health financing systems indicate that their performance is modest in terms of enrolment, risk pooling, and financial sustainability (Carrin, 2003; Carrin et al., 2005; Mathauer et al., 2017). While more studies have focused on their design and functioning, literature investigating into the question of impact of CBHIs on utilization of healthcare services and financial protection are scant. The few studies which are available indicate a limited impact for those enrolled with CBHI schemes (Baeza et al., 2002; Bhat et al., 2017). However, given that large sections of the population continue to spend significantly out of pocket, CBHI offers the potential to take health insurance to such communities with strong social capital and complement other healthcare services or health financing arrangements. CBOs such as MFIs, cooperative societies, SHGs, NGOs, and other forums which are spread across the country and have built trust among different communities can act as effective conduits for CBHIs, specifically, the mutual model (Bhat et al., 2017).

As a self-contained model of insurance, CBHIs face barriers in diversifying their risks, operating sustainably, and fulfilling the health and financial protection requirements of the target communities. These barriers also require them to resolve various trade-offs. While raising premium rates and scaling

up can help in moving towards financial sustainability, CBHIs have to account for affordability and proximity to communities to ensure that need-based and customized products and services are made available to them (Bhat et al., 2017). Beyond the current sources of funding available to CBHIs, including through donor support, there is a need to explore different mechanisms through which a sustainable CBHI model can be built. In this regard, regulatory assistance in creating Hub & Spoke model or facilitating re-insurance can be considered. The regulator can also consider lowering of capital requirement for setting up microinsurance companies to facilitate recognition and scaling up of CBHI models such as mutuals (IRDAI, 2020).

While the feasibility of CBHIs to operate as self-contained models of insurance and their ability to create a significant dent in the OOPE of communities remains to be seen, studies on prevalent models suggest viewing CBHIs as "entry points" to other larger pools or financing arrangements outside the scheme. These include commercial pools and government financed health insurance pools. Here, a significant portion of the risk would be held by an external pool. The objective of such an arrangement would be to leverage the core attributes of CBHI to drive enrolments in health insurance, improve health seeking behaviour, facilitate supply of need-based products, and organize communities to get better access to healthcare and financial protection (Baeza et al., 2002; Carrin et al.; Bhat et al., 2017).

As we think about and move towards UHC in India, it also becomes important to identify and delineate the role that each health financing arrangement, including CBHI, can play in the larger healthcare system, along with ways in which they can potentially interact with each other (Bennet, 2004). Making such linkages explicit can help in optimizing resource utilization in delivering quality health outcomes and enhanced financial protection to the population, particularly to the vulnerable sections.

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