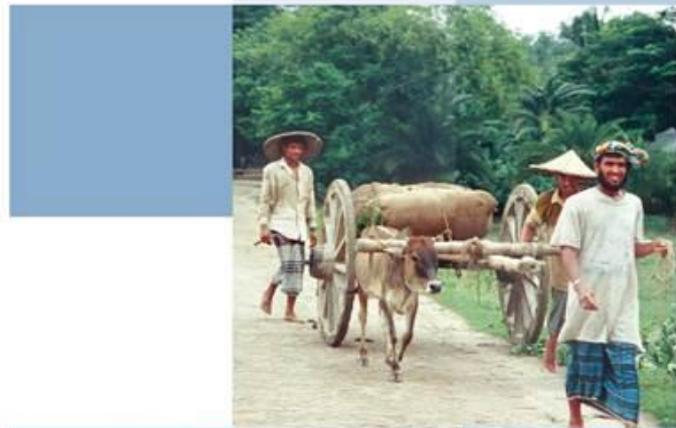


Evolving Microinsurance Business Models and their Regulatory Implications

Cross- country synthesis paper 1

August 2014



Authors:

Jeremy Gray

Hennie Bester

Christine Hougaard

Mia Thom

Peer Reviewers:

Arup Chatterjee

Gita Timmerman

Martina Wiedmaier-Pfister

Date: 08/08/2014

VERSION 2.2



Tel: +27 21 913 9510

Fax: +27 21 913 9644

E-mail: tessa@cenfri.org

Physical address: Regent House, Farm 2, 99 Jip De Jager Road,
Bellville, Cape Town, 7530, South Africa

Postal address: PO Box 5966, Tygervalley, 7535

www.cenfri.org

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About the project

The Access to Insurance Initiative (A2ii) is the implementation arm of the International Association of Insurance Supervisors (IAIS) on inclusive insurance. Part of this role is to extract relevant learning and build supervisory capacity.

It has been five years since the findings from the original five access to insurance diagnostics were synthesised into a cross-country report and a series of focus notes¹. In the interim a number of further microinsurance diagnostics have been completed under the A2ii umbrella, and several other studies² have become available that can inform a cross-country stock-take of trends and insights in microinsurance.

To update the cross-country synthesis picture, the A2ii, with co-funding from FinMark Trust, has commissioned two new synthesis papers to extract key overarching themes across jurisdictions. The aim is to enable insurance supervisors³ to better understand the workings of their low-income insurance markets, as well as to provide guidelines on potential regulatory and supervisory implications and responses.

This first paper identifies evolving microinsurance business models, the risks they give rise to and the consequent regulatory implications, whilst the second paper identifies the different approaches taken by regulators to catalyse microinsurance markets, the factors or determinants leading to a particular approach, and the impact of various approaches on market development.

Interplay between the papers. Paper 1 discusses potential regulatory implications and responses for supervisors arising from the evolution of specific business models within their markets. Which specific responses are deemed most appropriate within each market circumstance is determined by a range of broader constraints and considerations, foremost amongst which will be the overall regulatory approach adopted by the insurance supervisor – the topic of Paper 2. However, this is not a one way relationship as the choice of which regulatory approach will be optimal to adopt rests, at least in part, on the existing market environment and risks. Hence there is a two-way causal relationship between the market environment and regulatory responses to it, on the one hand, and the overall regulatory approach adopted on the other hand.

Methodology and scope

The two synthesis papers are based on an analysis of all A2ii diagnostics and several other studies. In total, 25 different jurisdictions were considered (see Table 1)⁴. Eight of the countries considered have already incorporated some form of microinsurance-specific regulation⁵. These do not all constitute comprehensive microinsurance frameworks. A further eight of the countries have proposed some form of microinsurance-specific regulation (indicated with a * in the table below):

¹All five of these case studies as well as the synthesis paper can be accessed at: www.access-to-insurance.org

² E.g. the “mini-diagnostic” in Ghana, the CIMA diagnostic and the Pakistan diagnostic, as well as several cross-country insights as captured in the second volume of the Microinsurance Compendium

³ Insurance Supervision refers to both regulation and supervision. Supervisors include regulators. (Insurance supervision within an individual jurisdiction may be the responsibility of more than one authority. For example, the body that sets out the legal framework for insurance supervision may be different from the body that implements it (IAIS, 2012).

⁴ Note that the four SADC (Southern African Development Community) countries which fall in this category (Botswana, Namibia, Malawi and Zimbabwe) were analysed as part of a wider study on the entire SADC region. A diagnostic was underway in Peru at the time of writing. There has also been work done on Mexico’s microinsurance sector, albeit no comprehensive overview diagnostic or study.

⁵ Regulations are classified as a ‘secondary form of regulation’ which have the legal force of law but are usually the responsibility of the supervisor (IAIS, 2012).

Country	MI Diagnostic/ country study	Year published	MI-specific regulations	Country	MI Diagnostic/ country study	Year published	MI-specific regulations
China	✓	2014	✓	Nigeria	✓	2012	
India	✓	2008	✓	Uganda	✓	2008 & forthcoming	
Mongolia	✓	2011		Lesotho	✓	2012	
Nepal	✓	2012		Mozambique	✓	forthcoming	✓
Pakistan	✓	2012	✓	* South Africa	✓	2008	✓ *
Philippines	✓	2008	✓	Swaziland	✓	2012	✓ *
Brazil	✓	2010	✓	Tanzania	✓	2012	✓ *
Colombia	✓	2008		Zambia	✓	2009	✓ *
Mexico		-	✓	Botswana		-	✓ *
Peru	✓	forthcoming	✓	Namibia		-	✓ *
Ethiopia	✓	2010		Malawi			
Ghana	✓	2009	✓	Zimbabwe		-	✓ *
Kenya	✓	2010					*Proposed

Table 1: List of countries considered as information sources

Note that all of the information considered is current as at the date that the studies used as input documents were published. It is beyond the scope of this analysis to update the latest developments in all the countries considered. In particularly important areas and specific cases, available updated information was used.

1. Introduction

One of the aims of the cross-country synthesis exercise is to gain a better understanding of the dynamics, development and evolution of microinsurance markets. Identifying discrete microinsurance business models allows the roles and incentives of the players involved in the provision of microinsurance to be disaggregated so as to better understand the way that the microinsurance market evolves across countries and to gauge the risks involved.

Different business models give rise to different combinations of consumer protection risks. Understanding which business models prevail in specific markets thus also results in a greater understanding of the kind of risks that predominate. Once the risks are identified, the analysis considers what the drivers of the specific risks are, as well as the regulatory implications of the business models. From this, appropriate regulatory responses can be designed for individual markets.

The document follows the following structure:

- Section 2 discusses the eight discrete microinsurance business models identified.
- Section 3 considers the cross-cutting market dynamics arising from the microinsurance business models and the resultant regulatory considerations.
- Section 4 identifies the major consumer protection risks that arise from these business models, examines the salient drivers of those risks, and lists the observed regulatory responses to each.
- Section 5 concludes.

2. Business models

This section explains how various business models are defined and categorised, describes each model and considers various scenarios in which different models can develop.

2.1. Categorising the business models

Distribution as core classifier. In the microinsurance market a business model⁶ can be defined as a composite of three elements: firstly, the product or service which the insurer underwrites and which mitigates a risk experienced by the insured; secondly, the manner in which the policy is sold to the policyholder, including how information about the policy is communicated to the policyholder; and thirdly, the manner in which the customer agrees to pay the premium and how it is collected. The second and third elements relate to distribution. Distribution includes the channels and actions through which an insurance company sells a policy to the policyholder as well as services the policy on an ongoing basis. The nature of distribution is the primary, but not only, parameter employed in this document to categorise the different business models. Distribution is of particular relevance to the insurance industry as insurance is typically sold and not bought, that is, the prospective client usually has to be engaged in a sales process by a salesperson before he or she makes a purchase. The relative difficulties in reaching the low income market due to limitations with infrastructure, poor connectivity, low education levels and limited experience with insurance underline the importance of

⁶ "The essence of a business model is that it defines the manner by which the business enterprise delivers value to customers, entices customers to pay for value, and converts those payments to profit: it thus reflects management's hypothesis about what customers want, how they want it, and how an enterprise can organize to best meet those needs, get paid for doing so, and make a profit." (Teece, 2010)

distribution innovation in microinsurance. Due to low premiums and thus low margins, the emphasis within microinsurance falls strongly on reducing distribution costs.

Other factors applied to distinguish between the business models are how the client makes the insurance decision and the discrete risk profile of each of the business models. In some instances, a further dimension comes into play, namely the way in which the insurance is underwritten (be it self-underwriting by a member-based organisation, or underwriting by an insurer or by the state).

Microinsurance typically entails a long value chain. Microinsurance is often characterised by a complex value chain, with multiple discrete players involved that can fulfil a range of potential functions. Figure 1 below illustrates the potential links in the value chain:

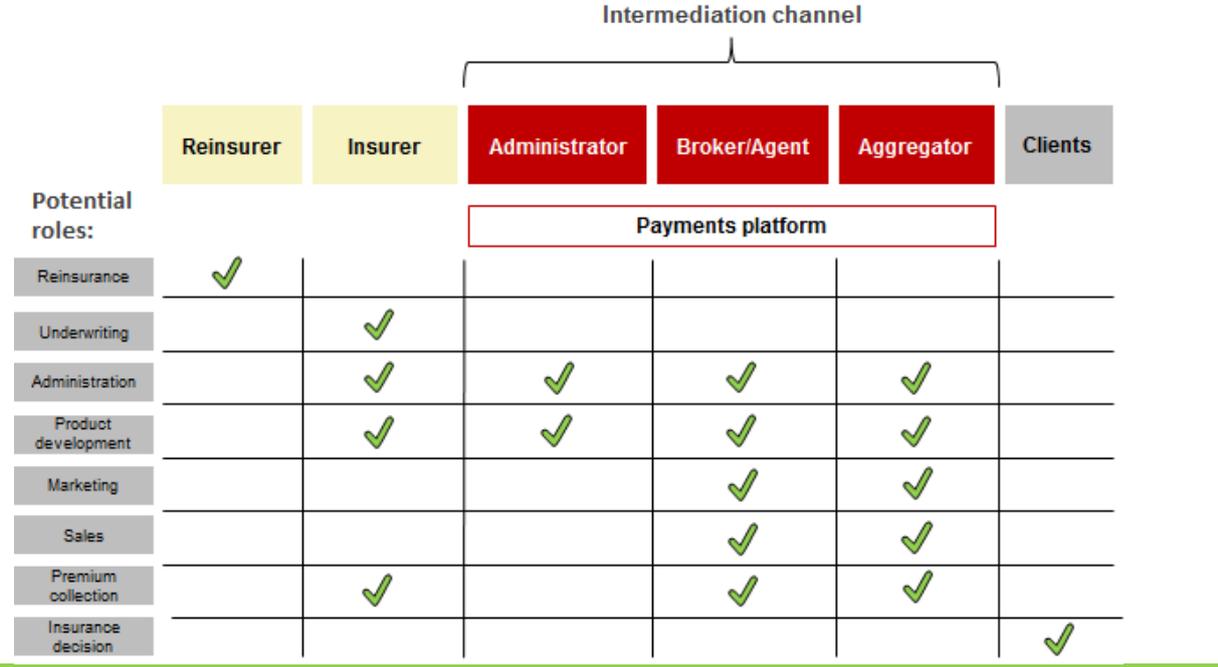


Figure 1: Value chain elements

Source: Authors’ own

The distribution of microinsurance typically includes a number of institutions, with an administrator⁷, a broker or agent and a third party client aggregator⁸ all potentially involved. This entails a greater degree of separation between the insurer and the client than a model that just uses a broker or agent, as a client’s direct interaction is often with the aggregator rather than with the insurer or broker. The administration and payments infrastructure and process may be provided by separate entities or the third party aggregator.

Long distribution channel heightens risk. The degree of separation and variety of entities involved in the distribution channel, some of which may not even be regulated by the insurance supervisor, results in heightened and distinctive consumer protection risks, as it increases the possibilities for

⁷ An administrator means a person or entity which has a mandate from an insurer to do administrative work, notably claims administration, on its behalf.

⁸ Client aggregators are entities, for example retailers, service providers, membership based organizations or civil society organizations, that bring together people for non-insurance purposes and that are then utilized by insurers, with or without the intervention of agents or brokers, to distribute insurance. In many instances, this is considered the most cost-effective way to service and reach large numbers of low-income clients.

exploitation, distorted incentives and misrepresentation. This makes distribution the most relevant classification parameter from a supervisor’s perspective.

The following distribution-related issues differentiate the various microinsurance business models defined and cause different market configurations:

- Who the client interacts with and the prior relationship between the client and that entity, in that it governs client perceptions and the bargaining power of the insurer vis-à-vis the aggregator or intermediary
- The level of trust that clients have in the intermediary or aggregator
- The nature of the insurance choice, that is, whether it is voluntary or compulsory
- The accountability of the salesperson
- The incentives of the different players and how visible these incentives are to clients
- The skills and competence of the salesperson
- Whether the client is paying the full premium or only a portion

2.2. The business models

Eight discrete microinsurance business models were identified during the synthesis process:

Business model	Description
Individual sales	Insurance products are sold to potential clients on a one-on-one basis through dedicated registered or licensed insurance agents or brokers. This may be through face-to-face interaction or through call centres.
Proxy sales force	Insurance is sold to existing clients of non-insurance entities where the policy is marketed with the sale of another product. Active sales persons are involved in the sale, but the salesperson works for the aggregator and the insurance is ancillary to the primary good that they sell. The product can be standalone (cross-selling to a third party client base) or can be embedded in an underlying service. The client’s insurance decision is voluntary in the case of cross-selling, but is often compulsory in the case of embedded products (implying that some may not even be aware that they have cover).
Compulsory insurance	Certain categories of citizens are compelled by regulation to purchase/contribute to prescribed risk covers. [Note: to be distinguished from mandatory insurance where a market player, such as a credit provider, makes the purchase of insurance cover mandatory. We refer to such types of insurance as “embedded” insurance and it is covered under the proxy sales force model.]
Group decision	Members of a group become policyholders by virtue of belonging to that group. The group policy is negotiated collectively. The group decision model can include either universal cover by virtue of membership to the group or an opt-in or opt-out option.
Local self-help	A group of persons (such as a mutual or another community-based organisation) pools its own risks.
Auto-enrolment	A third party purchases insurance on behalf of policyholders. This may be the state subsidising insurance on behalf of a class of citizens or a third party

	aggregator such as a mobile network operator or bank purchasing insurance for its clients as a loyalty scheme. The insurance is underwritten by a licensed insurer.
Passive sales	An individual purchases insurance without the active intervention of a sales person, for example through a retailer, responding to mass marketing or a mail shot campaign, or online.
Service-based sales	The client secures a service to be rendered in the future through an insurance policy. The insurance is offered on an individual and voluntary basis. The entity which sells the insurance is the same one that provides the service. The insurance may be underwritten by the provider itself or by an insurer.

Table 2: List of business models

Below, each business model is described in terms of its key characteristics, the players involved, their roles and incentives, examples of the model in question, and how it typically evolves. Note that not all these business models or all their features are unique to microinsurance. They are described because they are *also relevant* (or of particular relevance) to microinsurance.

2.2.1. Individual sales

One-on-one sales process. The first model can be termed the individual sales model. It is the classic model for insurance sales, and is found within the microinsurance space as well as in the traditional insurance market. As illustrated in Figure 2 below, sales are made on an individual basis through direct interaction between the client and an agent or broker. This can include both outbound and inbound call centres, so does not necessarily entail face-to-face interaction. However, there is no third party client aggregator involved. Note that some of the roles are indicated for more than one party. These are *potential* roles. Who fulfils what function will depend on the exact permutation of the model. The same holds for the roles indicated in the other business models.

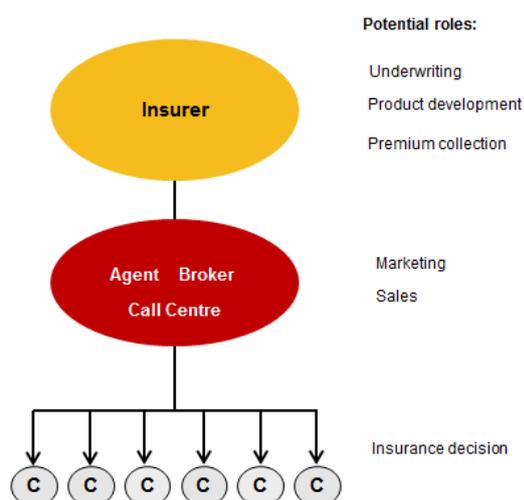


Figure 2: Individual sales model⁹

Source: Authors' own

⁹ Note that the roles or functions indicated in the diagrams refer to all the possible roles that *may be* performed by various parties. Not all roles are necessarily fulfilled by all parties.

The individual sales model is typically found in the upper end of the market and it is a natural progression for insurers to extend it to microinsurance, should they want to move down-market. This typically occurs in parallel to or before experimenting with mass distribution channels.

Players and roles

Potential clients reached through agents or brokers. Figure 2 illustrates the players in the individual sales business model and their respective roles. The insurer reaches clients through an agent, which is exclusively tied to the insurer, or broker, which is merely affiliated to the insurer and intermediates policies from multiple insurers. The insurer is responsible for underwriting, product development, premium collection and administration. The intermediary’s primary function is traditionally marketing and sales. However, brokers may also engage in administration, product development and premium collection. Agents can undertake the collection of premiums. This model entails active selling; the intermediary approaches the client to make the insurance sale.

Examples

The individual sales model can manifest in two ways:

- Agents contracted by either the insurer or the broker engage in face-to-face interactions with the client and are paid on commission.
- Call-centres, both outbound and inbound, which can be owned and run by either the insurer or the broker, engage in telephone-based sales. These call centres frequently rely on an existing database to identify potential clients. There is no face-to-face interaction.

Box 1: Examples of individual sales models – the case of Brazil

SINAF Seguros

SINAF Seguros, operating in the Rio de Janeiro area since 2006, sells microinsurance door to door. SINAF sells policies ranging from R\$12.50 (US \$7) to R\$30 (US \$17) per month, offering various levels of cover. The main component is funeral assistance (provided by a SINAF sister company), as well as “income replacement” in the case of death, whereby the beneficiaries receive a fixed amount per month for a fixed number of months, depending on the level of cover chosen. SINAF policies are sold through a sales force of 110 broker representatives. In 2010, SINAF covered more than 500,000 lives (100,000 primary policy holders), all in the C, D and E classes¹⁰. SINAF is unusual in the Brazilian environment, where the conventional wisdom is that individual, outbound face to face sales are not viable for microinsurance (Bester et al., 2010, p. 57).

AON and Marsh

Corporate brokers AON and Marsh play an important role in the affinity business channel selling insurance to the clients of utility companies, telephone networks and other aggregators. Many of these mass market clients are likely to be lower-income. They mainly use outbound and inbound call centres and mail shots for marketing. The call centre components are classified in the individual sales category. They mine the client databases of the aggregator to ensure effective targeting and apply advanced administrative systems to enhance efficiency. In several cases these brokers have also taken on an extensive administration role, resulting in some insurers being relegated to an underwriting vehicle (Bester et al., 2010, p. 25).

¹⁰ The A-E socioeconomic classification is a commonly used measure in Brazil. It is not based on income, but rather on a range of socioeconomic variables such as asset ownership and education. Individuals falling into classes C, D and E approximately correspond to those earning below 3x the minimum wage and most would individuals in these categories would therefore be considered low income.

Evolution

Although relatively expensive, agents can maximise revenue. As the discussion below will show, many microinsurance models involve adopting mass distribution channels in an effort to reduce distribution cost and reach scale. However, experience is starting to show that revenue can actually be increased through active face-to-face sales. There is evidence of a post-mass distribution movement ‘back to the agent’ as the advantages of one-on-one interactions become apparent¹¹.

2.2.2. Proxy sales force

Insurance sold by aggregator’s employees or contracted agents. The second model is the proxy sales force model. The key descriptor of this model is that the insurance product is not sold directly by the insurer or by an independent insurance broker or agent, but rather by a non-insurance third party to their existing clients (referred to as the aggregator). The policy is marketed with the sale of another product and can be sold as either an embedded product or by cross-selling. The insurance product is actively sold, but the salesperson works for the aggregator and the insurance is ancillary to the primary good that they sell. The primary client relationship is therefore not insurance-based and the insurer reaches the client through an aggregator such as a retailer, utility, bank or credit provider. The employees or contracted agents of the aggregator can be regarded as a ‘proxy sales force’ for the insurer. To intermediate insurance, these “proxy sales forces” require some form of licensing or registration from the insurance supervisor.

Players and roles

Intermediary controls the sales force. Figure 3 below illustrates the players in the proxy sales force business model and their potential respective roles:

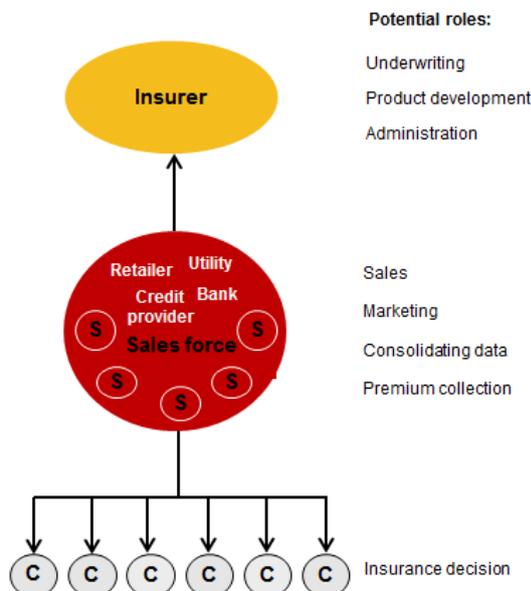


Figure 3: Proxy sales force model

Source: Author’s own

¹¹ Consultations with Hollard in South Africa indicated that using agents to actively sell policies in their partner retailer’s stores have increased sales by in excess of 350%. Avbob (South Africa) and Tigo (Ghana) also indicated that active selling through agents has a substantially higher success rate than alternative distribution channels (Thom et al, 2014).

The role of the insurer includes underwriting, product development and administration, whilst the third party aggregator is responsible for sales, marketing, consolidating the client data and premium collection. The sales force in this model does not rely on insurance sales commissions for their full income, which permits lower sales volumes by each individual salesperson. Therefore, a wider variety of people can be employed. The incentive for the aggregator is to maximise revenue through an alternative revenue stream and also potentially to increase client loyalty by binding the client through multiple relationships. Where third party aggregators offer embedded products such as credit insurance, the incentive would be to mitigate its own risk against client default. The insurer's incentive is to access the third party aggregator's client database in order to increase volumes.

A key aspect and potential risk arising from the proxy sales force model is that the aggregator owns the client base and provides the sales force, whilst insurers often compete to underwrite the book. As will be apparent when the business model dynamics are discussed in Section 4, this bestows substantial bargaining power on the distribution channel vis-à-vis the insurer.

Examples

The proxy sales force model can be divided into two types of insurance offerings:

- Embedded products, such as credit life, which are added on the back of the underlying service or product (financial or non-financial), such as the provision of credit. The insurance is mostly compulsory for clients who purchase the service or product.
- Cross-selling, which involves insurance being sold as a standalone product, but marketed with another product. Bancassurance, for example, can entail the sale of insurance with other bank products, while extended warranties are insurance products sold with the sale of durable goods. The insurance decision is voluntary.

Box 2: Examples of proxy sales force models

Casas Bahia - Brazil

Casas Bahia is the largest white goods chain store in Brazil, with more than 500 stores in 11 states (Casas Bahia, 2009)¹². It sells various insurance products on its premises; including extended warranties and credit life insurance on goods purchased on credit.

Casas Bahia's sales force acts as salespeople for the insurance policies. Though they are not employed or remunerated directly by the insurer (they are remunerated by the retailer from the so-called *pro labore* allowance the insurer pays it for insurance sales), the insurer provides them with training¹³. Each salesperson receives on average 7 hours of training. It does not involve an exam, but role play and mystery shopper techniques are used to test their sales capability and knowledge of the insurance product (Bester et al., 2010, p. 51).

CODENSA-MAPFRE - Colombia

CODENSA is the largest electricity distribution company in Colombia. In response to increased competition, CODENSA has since 2002 been developing a customer loyalty programme to strengthen its customer base. A core component of the strategy is to offer customers alternative, non-electricity products that can be paid through their electricity bill. In order to develop their insurance offering, CODENSA entered into a partnership with Mapfre Insurance in 2003.

CODENSA contributes its customer base, brand and premium collection mechanism to the partnership, while Mapfre is responsible for designing and underwriting the insurance products. In recent years, CODENSA has started to identify different types of needs among its customers and has

¹² <http://www.casasbahia.com.br/pesquisaLojas.do>

¹³ The insurer also pays for the training.

played a more active role in suggesting the design of products that meet these needs to Mapfre.

The insurance is sold by the CODENSA sales force, which is trained by Mapfre in the technical aspects of insurance necessary for assessing the customer. CODENSA also provides the team with training in sales and marketing (Zuluaga, 2010, p. 6).

Protecta – Peru

Protecta was launched in December 2007 by Grupo ACP with the purpose of targeting the microinsurance and mass insurance markets in Peru, thereby becoming the first Peruvian insurer to specifically target this market. Protecta's initial client base came exclusively from another Grupo ACP subsidiary – the MFI MiBanco, through which Protecta provided embedded credit life insurance. This allowed Protecta to reach approximately 500 000 customers. Since then, Protecta has pursued alternative distribution channels, including universities, municipalities and a chain of pharmacies. However, MiBanco still contributes the vast majority of Protecta's total client base, accounting for about 800 000 customers out of a total of c. 1.3 million (Thom et al., 2014).

Evolution

The proxy sales force model typically develops where insurers take advantage of large pre-existing client bases and the infrastructure and established communication channels offered by third party aggregators such as retailers, banks and utilities:

- *Embedded products* evolve from the demand for the underlying product, most frequently credit. In the case of credit insurance, the supplier's need for protection against default risk is also a major driver. Often, the first step is for providers, especially MFIs in the case of credit, to price for the risk internally without formal underwriting by an insurer. As the book grows, or if there are adverse experiences, they may seek underwriting from an insurer. Likewise, as the insurance market develops, insurers may start to see the opportunities for underwriting these risks and may approach providers to take on their books.

Embedded products are often the first to be sold in a microinsurance market as the embedded nature means it is relatively easy for insurers to achieve scale and profitability. If it provides value to customers, it can act as an important initial enabler of market development, firstly as it familiarises the market with the concept of insurance, and secondly because it demonstrates the potential mass market insurance opportunities to insurers, leading them to branch out into other types of microinsurance as well. However, in practice many consumers are not aware of their cover and it is the credit provider, rather than the consumer, that primarily derives value from the product.

- *The cross-selling model* may be instigated by:
 - the insurer, who benefits from access to the third party's existing client base and an easy existing contact point to the target market;
 - the aggregator, who benefits through increased service offerings to customers, leading to greater customer loyalty and through adding an additional revenue stream; or
 - a third party administrator or corporate broker, which acts as a "match-maker" between the insurer and the aggregator.

Cross-selling is often more prevalent in more developed retail insurance markets as it requires the financial services or retail market to be established, with third parties starting to be interested in how to diversify their income stream. However, diagnostics have also found this model in underdeveloped retail insurance markets, instigated by a third party administrator or broker. Where insurers are struggling to get into the retail insurance market with their traditional distribution models, it can be a

comparatively attractive route to piggy-back on the existing client base and infrastructure of another organisation.

2.2.3. Compulsory insurance

Insurance required by regulation. The compulsory sales business model refers to insurance products, for example third party liability insurance for vehicles and social health insurance schemes, which regulation requires certain categories of citizens to have. Compulsory insurance may be partially subsidised by the state, but citizens are required to pay at least part of the premium. It should be distinguished from embedded insurance where a commercial party, for example a credit provider, requires the customer to buy insurance as a condition to accessing the credit, or auto-enrolment insurance where insurance is provided at the behest of a third party that pays the entire premium.

Players and roles

State as key figure. Figure 4 below illustrates the compulsory sales model. The fundamental driving factor of compulsory insurance is the state. The state makes the policy compulsory for individuals, who are required to pay the premium. Clients can access this insurance from any available insurer offering the product through their normal distribution channels (hence there are no lines drawn in the diagram, as more than one insurer can work through various intermediaries to reach the end-clients). The regulation prescribes the product parameters and it is then the responsibility of the insurer to develop the product, underwrite the insurance, collect the premiums and administer the policies. In some instances, the state may also act as the insurer and fulfil all of these functions¹⁴. The state can also place requirements on third parties to collect premiums, for example where employers are required to collect premiums from their employees.

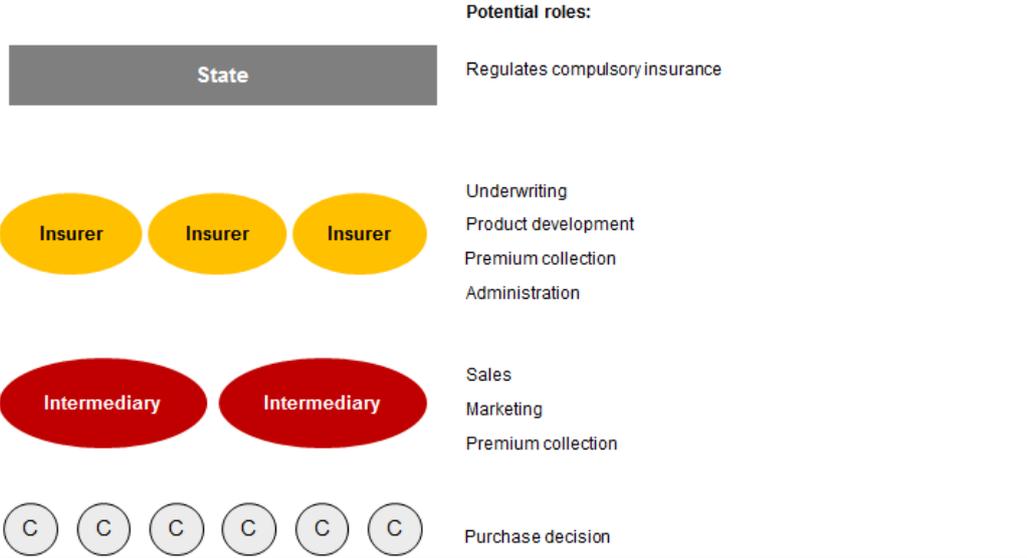


Figure 4: Compulsory sales model

Source: Authors' own

¹⁴ This arrangement will be outside the scope of supervision of an insurance supervisor and may lead to the crowding out of private players from the market.

Examples

Third party motor vehicle insurance¹⁵, which is compulsory in the vast majority of global jurisdictions, is the most common form of compulsory insurance. According to the Motor Insurance Working Group (2010), 176 out of 196 jurisdictions have some form of compulsory third party motor vehicle insurance (Zimolo, 2010, p. 16). Other types of compulsory insurance may include social health insurance, unemployment insurance, workmen's compensation insurance, or liability cover for certain provisions.

Box 3: Examples of compulsory models

DPVAT - third party motor vehicle insurance in Brazil

Compulsory third party liability coverage, DPVAT (Danos Pessoais Causados por Veículos Automotores de Via Terrestre), is one of four main lines of auto insurance in Brazil (private passenger, automobile and auto civil liability are the others). The 2010 Brazil diagnostic study found that it grew at an average annual rate of 12% since its introduction in 2003 (Bester et al., 2010, p. 33).

National Health Insurance Fund (NHIF) Tanzania

The NHIF was set up in 2001 in recognition of the need to use social insurance as a financing tool to achieve effective cross-subsidisation towards the goal of universal coverage. It is compulsory for public sector workers only, though there are plans to extend coverage. About 2.5 million individuals (including main members, spouses and children) were covered in 2010.

The NHIF covers main members, their spouses and up to four children and/or dependents. Premiums are equal to 6% of a member's salary – 3% is deducted from a member's salary and 3% is contributed by the member's employer, that is, the state (Hougaard et al., 2012).

Evolution

Response to unmet needs in the public interest. The compulsory sales model typically evolves in response to specific public needs. The state identifies major unmet risks in the public interest. These are typically related to public and private transport, labour protection and social protection. For example, the legislative requirement for compulsory third party motor vehicle insurance is designed to protect road users, whilst compulsory social health insurance for the formally employed is a response to the overall health needs of the employed population.

In countries where retail and life insurance is very underdeveloped and commercial asset insurance policies account for the bulk of the insurance market, compulsory models can be the origins of a microinsurance market (and indeed of the retail market, more broadly). This tends to be most successful in cases where social protection insurance is subsidised wholly or in part by the state.

2.2.4. Group decision

Membership defines cover. In the group decision model, the members of a group are insured by virtue of being members of a pre-existing group, which negotiates the insurance on behalf of members, rather than through an individual decision. The group decides collectively to obtain

¹⁵ Note that third party motor vehicle insurance is not necessarily microinsurance. However, a broader conception of microinsurance would see it as a relevant product in the microinsurance market, e.g. for those who own entry-level second hand vehicles and for otherwise-excluded individuals for whom this may be the first insurance product. In markets where there are abuses in this market, it may have an impact on microinsurance more broadly. Furthermore, the existence of compulsory third party insurance may form the basis for the development of a microinsurance market where retail insurance is otherwise limited.

insurance¹⁶. The incentive for the group is to provide its members with an additional value added service, as well as to increase the loyalty of the members to the group. By insuring an existing group, the insurer can reach a large number of clients through a single interaction. Group rather than individual underwriting is applied, meaning that no evidence of insurability has to be submitted on an individual basis, and the policies are typically administered through the group’s infrastructure. Both of these elements can reduce costs. The insurance policy may be universal cover by virtue of membership to the group or individual opt-in.

Players and roles

Insurer fulfils most functions directly, unless broker or agent involved. Figure 5, below, illustrates the group decision model and shows the roles of each of the relevant parties involved in the model. The group can either negotiate the insurance directly with the insurer or through a broker, agent or administrator.

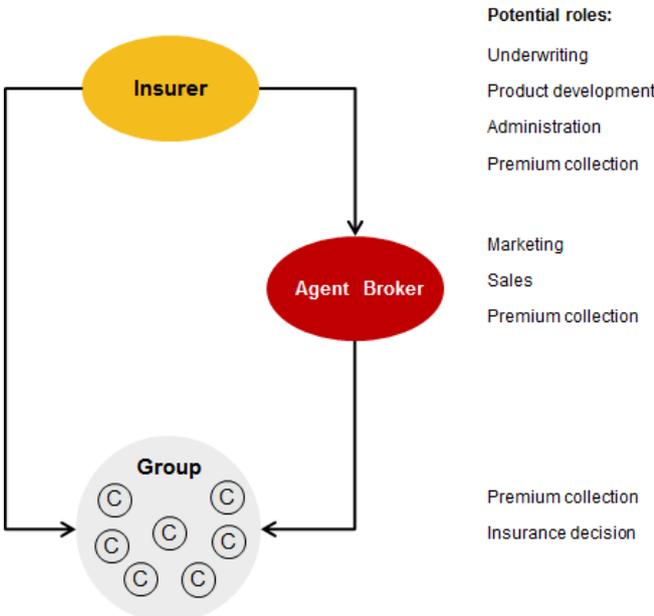


Figure 5: Group decision model

Source: Author’s own

The insurer’s roles include underwriting, product development and administration and may include premium collection, marketing and sales. If there is a broker or agent involved in the value chain, then they would be responsible for marketing and sales and possibly for premium collection and some of the administration. Premium collection, therefore, may occur at any of the three levels – the group may collect the premiums from its members and then pay the lump sum to the insurer, the

¹⁶Generally, for any group policy, the group or group organiser or manager is the master policyholder, but the individuals are the insured. The group thus holds a master policy and individuals do not each have an individual policy document. Instead, they may be issued with individual certificates indicating their cover under the master policy and their corresponding premium obligation. Where this is not the case, the master policy is simply accompanied by a list of insured persons. Claims are paid directly to the insured individual rather than to the master policyholder. Group policies are particularly relevant to the group decision and auto enrolment models but may also exist in the proxy sales force model and service based sales model. In certain cases the master policyholder can be regarded as the insured and the individuals as beneficiaries. Where this is the case, such as an employer that pays premiums on behalf of employees as a service benefit, the master policyholder as the insured receives claims and then disburses it to individuals.

broker or agent may collect the premiums on behalf of the insurer or the insurer may collect the premiums directly.

Examples

There are three generic forms of the group decision model:

- Trade unions are a common example of the group decision model. Due to competition between unions for members, offering financial services as a value added service can create a competitive advantage for the union in attracting new members and in improving loyalty amongst existing members.
- Cooperatives or other member-based organisations are another frequently observed manifestation of this model. Cooperatives are organisations that are owned and run jointly by members which share in the benefits. The cooperative must obtain insurance cover for its members from an external insurer and not underwrite the insurance itself in order to be considered a group decision model.¹⁷
- Employee and self-employed industry groups – such as producer groups, taxi drivers or other associations and artisan groups – may decide to seek insurance as a collective group from an external insurer.

Box 4: Examples of the group decision model

Shanxi village model - China

Selling group insurance through village committees is a uniquely Chinese distribution method for microinsurance pioneered by China Life's Jinzhong Branch.

In January 2009, China Life's Jinzhong Branch sold the first group policy to Dongpao Village in Dongguan Town of Qi Xian to provide microinsurance for all the villagers under a model of "One policy for the security of the family, the group and the whole village." Because this model was first piloted in Shanxi, it is often referred to as the 'Shanxi model'.

With this model, microinsurance products are introduced to representatives of a village – the village committee. Village committees are common throughout rural China. Through a process of consultation between prominent villagers, the village committee and an insurance salesperson, the village committee organises microinsurance on behalf of the entire village. There is one policy that covers all qualifying villagers, which are collectively the insured group. Individual villagers are not underwritten. However, insurance companies can vary premiums depending on what they know about the specific circumstances and risk profiles of different villages in different regions. The premium may be paid by the individuals or on their behalf by the group committee (Wei et al., 2014).

SADTU (South African Democratic Teachers Union) – South Africa

SADTU, like many South African trade unions, offers a number of financial services, including insurance, to its members. SADTU was formed in 1990 and has a membership base of over 250 000. SADTU utilises an external company (Shimba Financial Consultants), which negotiates the provision of financial benefits on behalf of their members. Shimba was appointed in 2009 to serve as the union's financial services broker and is tasked with the responsibility of negotiating financial services and products for SADTU members at discounted rates. Shimba is not paid by SADTU as it receives commission from the financial services providers when SADTU members take up products. In most instances, Shimba serves as the deal maker and is not involved in the administration processes.

SADTU, through Shimba, offers members both compulsory funeral insurance and voluntary funeral insurance options offered in partnership with insurers. Members are informed of the compulsory product when they are recruited. Members are also informed at schools and on the insurer's website.

¹⁷ Where the cooperative or a mutual or other member-based organisation acts as underwriter it will fall under the local self-help model.

In addition, SADTU has negotiated funeral insurance products at discounted prices through agreements with various insurers. These products are voluntary products and SADTU is not involved in the administration process. SADTU informs the members of these voluntary products at meetings. Insurers that SADTU has agreements with are invited to the SADTU meetings to market their products (Ncube et al, forthcoming).

Evolution

Existing groups offer growth opportunity for insurers. The group decision model evolves where there are existing groups that can reduce distribution costs for insurers. The group decision model may be an insurer's first venture into microinsurance as the access to an entire group allows insurers to achieve scale with a relatively low initial investment. Insurers may actively seek out groups in order to take advantage of the group's existing member base and infrastructure. However, groups, particularly those operating in a competitive environment such as trade unions, may also initiate the model by approaching insurers as they endeavour to offer value added services to members. This model may furthermore develop in the presence of a strong administrator or broker that seeks out groups with relatively more capacity and matches them with insurers so as to catalyse insurance group decisions.

2.2.5. Local self-help

Collective risk pooling with guaranteed benefits. The local self-help model refers to a group which collectively pools its own risks, as opposed to engaging the underwriting services of an insurer (the group decision model). The group collects the premiums from its members and pays out the claims itself. Another essential feature is that the benefits are guaranteed. This distinguishes the model as a microinsurance model from informal risk pooling where the benefits are not guaranteed. There is also a distinction between local self-help initiatives which only provide insurance to members and those which also offer insurance to non-members.

Players and roles

Group provides own risk mitigation service. Figure 6, below, illustrates the players in the local self-help model and their respective roles. The group pools the risk of all of its members and effectively performs all the roles in the insurance value chain itself. In some cases, non-members may also be permitted to access the insurance. The roles of the group therefore includes: underwriting, product development, premium collection, administration and, if non-members are permitted, sales and marketing:

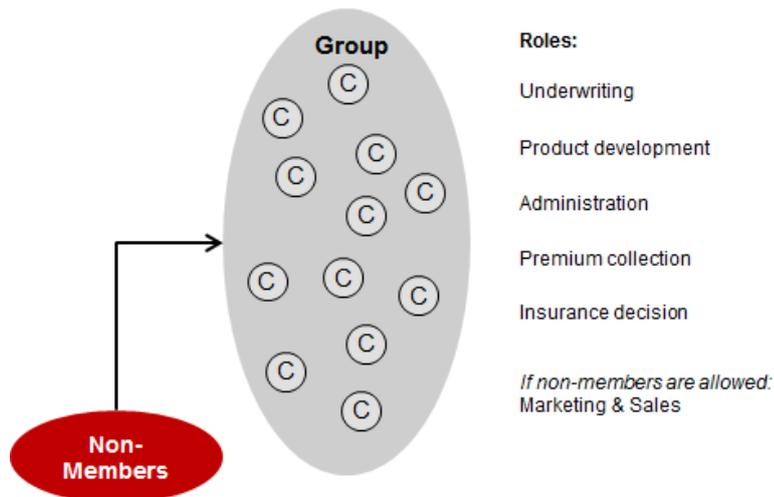


Figure 6: Local self-help model

Source: Author's own

The biggest incentive for the self-help group to offer insurance to members is that members experience risks which they are unable to mitigate on their own, yet they do not have access to affordable formal insurance. The local self-help group model allows individual members to pool risk among members, thereby mitigating the financial impact of risks. In some instances an external party, such as an NGO or technical assistance provider may encourage the formation of groups and render some services to the groups.

Examples

There are at least four examples of local self-help groups:

- Common bond societies such as friendly societies or other mutuals with an existing non-insurance bond. They recognise the need for individual risk mitigation and so decide to pool the risks of their members. The benefits to members must be guaranteed to qualify as microinsurance.
- Funeral assistance providers/ funeral homes, where all the functions of the model are centralised in the funeral home.
- Microfinance entities that underwrite the risks of their clients internally.
- NGO models - community organisations that are made up of local community members which pool their risks without another common bond. This model may arise from initially informal risk pooling organisations that do not at the outset offer guaranteed benefits, but then grow and formalise.

Some of these examples may be regulated whilst others are not.

Box 5: Examples of local self-help models

Mutual Benefit Associations (MBAs) - Philippines

MBAs are a type of insurance provider allowed for in the Insurance Code of the Philippines. They are defined as any society, association or corporation organized for the following purpose: i) paying sickness benefits to its members; ii) providing financial support to members out of employment and iii) paying relatives of deceased members a pre-agreed amount of money. Only members that

regularly pay a contribution (premium) are able to access the benefits.

Various types of institutions and associations organize MBAs to provide for the risk protection needs of their members. For example: MFIs may organize an MBA as vehicle for credit life insurance, while the Philippine Public School Teachers Association (PPSTA) provides for the risk protection needs of public school teachers (Lanto et al., 2008, p. 42).

The Self-Employed Women's Association (SEWA) - India

SEWA was established in 1972 by a small group of women as an informal community support group. It now represents over 1 million poor women working in the informal economy, mainly home-based workers, street vendors, manual labourers, service providers and small producers.

SEWA offers various financial services, including savings, credit and insurance, all provided internally. It has been offering health, asset and life insurance since 2004 (ILO, 2009).

Evolution

Latent demand and limited alternatives drive evolution. The local self-help model represents the origin of insurance in many societies. It develops in the absence of appropriate or accessible formal alternatives, where people do not trust formal options, or when individuals prefer own provision on the basis of solidarity. Strong community ties are generally a pre-requisite to the development of the local self-help model.

2.2.6. Auto enrolment

Individual is insured despite no own input. This model is characterised by the fact that a third party purchases insurance on behalf of a pre-determined group of people¹⁸. The third party may be the state subsidising insurance on behalf of a class of citizens or a provider of retail services such as a mobile network operator (MNO) or bank purchasing insurance for its clients as a loyalty benefit. The insurance is underwritten by commercial insurers (private or state owned) and the premiums are paid directly to the insurer by the third party. The contractual relationship within the auto-enrolment model is between the third party and the insurer, rather than between the insured and the insurer.

Third party is master policyholder. As with group decision policies, the third party is generally the master policyholder, but the individuals are the insured. Individuals may be issued with individual certificates indicating their cover under the master policy. Claims are paid directly to the insured individual rather than to the master policyholder.

Players and roles

Third party initiates and pays for the insurance product. Figure 7, below, illustrates the players and their respective roles in the auto enrolment model:

¹⁸ This distinguishes it from compulsory insurance, where the individual is required by law to purchase the insurance.

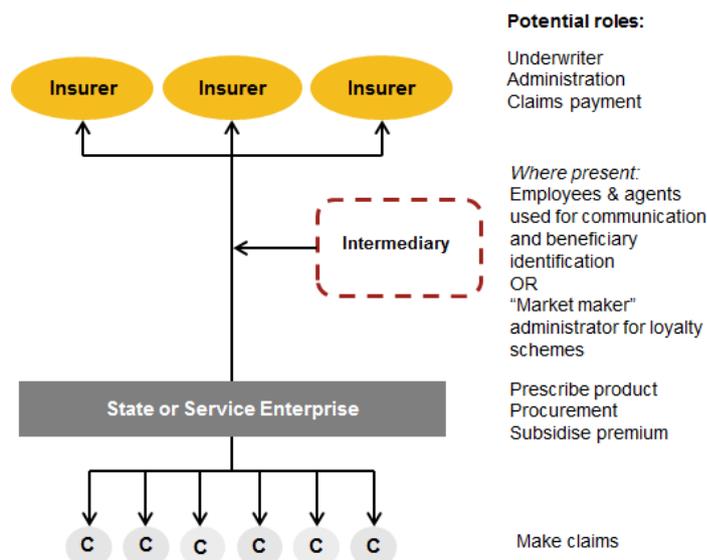


Figure 7: Auto enrolment model

Source: Author's own

A third party, either the state or a private operator seeking loyalty benefits for its customers, decides to provide and fund insurance for the selected group of individuals. An insurer is procured by the third party to underwrite, administer and pay the claims to beneficiaries. As the insurance policy is not purchased by the insured party, communicating to the insured party that they are covered by the policy and the details of the policy, particularly how to claim, is a key role for either the third party or the insurer, or both. Employees or agents of the insurer or third party may be utilised in the communication process and in identifying beneficiaries when claims are processed and paid. An administrator or broker may also be involved as 'market maker' bringing together the insurer and the third party. As this party is not necessarily always present, it is indicated by a perforated box in the diagram. In the auto-enrolment model, clients have no insurance decision as they are automatically enrolled in the group policy.

Examples

The auto-enrolment model can be divided into two branches, based on which entity is subsidising the premium:

- Public provision, where the state subsidises the premium. The state decides to use public funding to meet a specific public need and then enlists commercial insurers to underwrite and distribute the insurance.
- Loyalty benefits, where the premium is subsidised by a provider of retail services (such as a mobile network operator or a bank). The retail service provider wishes to offer a value added service to clients so as to add and retain customers, whilst the insurer gains access to a large client base.

Box 6: Examples of auto-enrolment models

BISP Waseela Sehat Programme – Pakistan

The Benazir Income Support Programme (BISP) was started in 2008-2009 by the government of Pakistan as a mechanism through which to distribute various social security benefits. Waseela Sehat is the microinsurance arm of BISP, providing fully subsidised life insurance to over 4 million of Pakistan's

lowest income households.

This insurance is underwritten by the State Life Insurance Company (SLIC), which is paid directly by BISP as administrator of the policies. All households identified to qualify are automatically enrolled into the policy and then sent relevant information regarding the policy and policy certificates via post. This leads to significant issues in terms of a lack of policy awareness, and is identified by BISP as the major reason for the exceedingly low claims ratio (Thom et al., 2014).

Rashtriya Swasthya Bima Yojana (RSBY) – India

RSBY is a national health insurance scheme in India which was started in 2008. By the end of 2010, the scheme had been launched in 340 districts in 25 states and covered approximately 63 million beneficiaries.

The initiative is fully state-subsidised with automatic enrolment and is underwritten by various insurers. Although utilisation rates were initially low, research indicated that villages in which there had been at least one successful claim had a higher usage rate, indicating that public awareness was, at least initially, an issue. However, as awareness has grown, so has usage and the scheme reported a claims ratio of about 80% in 2009-10 (Ruchismita & Churchill, 2012, pp. 448-449).

NMB Faraja – Tanzania

Tanzania's National Microinsurance Bank (NMB) offers automatic free funeral insurance, underwritten by African Life, to all active holders of the NMB Personal Accounts. The funeral product, which covered 2.4m lives (1.2m accounts) in 2012, provides cover of TZS 600 000 (USD \$380¹⁹) on the death of active NMB savings account holders and their spouses (Hougaard et al., 2012, p. 29: doc 5). Corporate brokers play an important role as market-makers for such models in Tanzania.

Evolution

State social mandate drives public provision. Public provision auto-enrolment develops from a strong state mandate and social goals to improve the social situation of a specified group of the population. In some cases, the public drive may be in response to market failures, that is, the state finds that the market does not provide risk solutions to a certain target market and decides to step in. In other instances, the state will be the proactive party, deciding where it wants to mitigate risk without consideration of why market forces can or cannot reach the target market.

Role of market maker in loyalty benefit schemes. Loyalty benefit auto-enrolment is frequently catalysed by a third-party 'market-maker' such as an administrator or commercial broker which recognises the potential for a partnership and brings the two parties together. Embedded loyalty products would naturally evolve in more developed insurance markets, with well-developed aggregators that recognise the benefit of offering insurance as a value added service. However, due to the role of market makers such as corporate brokers/administrators, there may be "first-mover" models as well, triggering the evolution of a microinsurance market in countries with very underdeveloped insurance markets. The reason is that in countries where the retail insurance sector is still very small and consumer awareness is very low, the most immediate opportunity for extending the reach of the insurance market may be to give free/automatic cover to a large existing client base. This creates the opportunity for the insurer to upsell voluntary products to existing beneficiaries. It should be noted, however, that most of these initiatives are still in the early stages of development.

¹⁹ Calculated on one year average exchange rate from www.oanda.com

2.2.7. Passive sales

No direct intervention from salesperson. In this model, the conventional mantra is reversed – insurance is bought and not sold, although it may be marketed. The potential client uses a passive sales outlet provided by the insurer to purchase the product, for example responding to brochures or mass market advertising. The onus is upon the client, rather than a salesperson or intermediary, to inform themselves about the product as there is no individual communication prior to the sale. There may be communication following the sale, for example where a call centre contacts the client to confirm their details and complete the transaction.

Players and roles

Potential client approaches the insurer. Figure 8 illustrates the passive sales model and details the roles of each of the players:

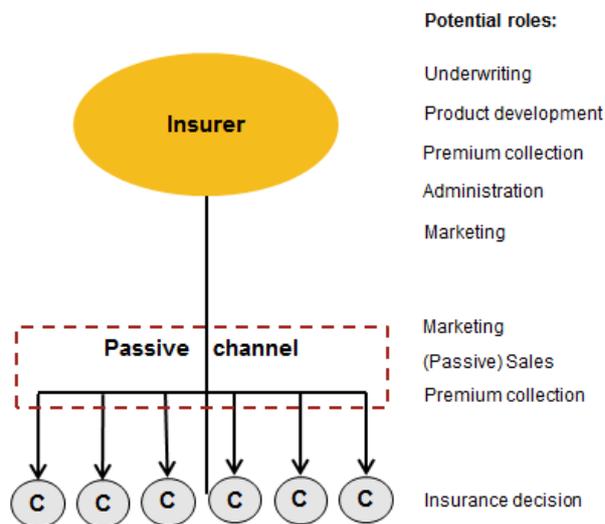


Figure 8: Passive sales model

Source: Author's own

The insurer provides the insurance products and its roles include: underwriting, product development, premium collection, administration and marketing. The client approaches the insurer to buy the insurance product, rather than an intermediary actively selling the insurance. Thus, although the insurer may market the product, there is no active selling of it and no intermediary. Note, however, that the premises of a third party such as a retailer may be used to sell insurance through passive sales techniques (for example placing product brochures in-store, or literally selling insurance cards or coupons off the shelf). The perforated box depicts that third party premises are not always present in this model.

Examples

The passive sales model manifests in two main ways:

- Through a virtual environment in which the client purchases the insurance policy directly online from the insurer.
- Through an aggregator in the form of “off the shelf” sales of insurance policies where no in-store sales agent is involved.

Box 7: Example of Passive sales model

Pep/Hollard – South Africa

Pep is a South African retail chain with about 1250 stores across the country that primarily targets the low income market. In 2006, Pep and insurer Hollard launched a funeral product that literally hangs on the shelf in Pep stores. The insurance pack contains a description of the cover and all the relevant policy documentation. There is no active sales process and no in-store agents. Some marketing is done in-store, but this is limited in scope.

Customers choose an insurance starter pack and pay their first premiums at the cashier, who also collects a copy of the ID and beneficiary information. Clients are then responsible to pay future cash premiums each month in store. SMS reminders are sent out to remind clients to return to make premium payments in-store, and clients also have the option to pay in advance.

As of July 2013, the joint venture sold four funeral products with varying premiums and benefits and had approximately 600 000 active policyholders. One of the attractions of the product to customers is its relative affordability to comparative industry products (Thom et al., 2014).

Evolution

Requires requisite supporting infrastructure. This model typically evolves where insurance has to some extent become "commoditised", for example funeral insurance in South Africa or personal accident or household insurance sold through utilities or retailer chain infrastructure in Latin America. A prerequisite is that the target market must be familiar enough with the concept of insurance and must trust companies enough to proactively buy insurance in response to general marketing efforts. It is therefore typically not found in very underdeveloped markets. The growth and reach of the internet may also be an important factor in the development of virtual models. As there is no direct interaction between a salesperson that can verify client details and the potential client, the existence of a national identification database against which client identity can be verified is also important to the development of virtual models.

2.2.8. Service-based sales

The service provider provides or intermediates the insurance. The service-based sales model is derived from underlying demand for another service. The client wants to secure a service that they will need in future (be it a medical service or a funeral) and, in order to be able to afford it, buys an insurance policy through the provider of the underlying service. The primary demand is therefore for the underlying service, and the demand for insurance is derived from it. The entity that sells the insurance is the same one that provides the underlying service. No insurance intermediaries are involved in the distribution of the insurance. Unlike in the local self-help model, where the group itself conducts underwriting/risk pooling, the insurance may be underwritten by an insurer or by the service provider itself (often informally). A further important determinant of this model is the nature of the risk retained by the provider. Only initiatives which offer guaranteed benefits to clients are considered microinsurance and therefore are classified as service-based sales models.

Players and roles

Most roles centred in service provider. Figure 9, below, illustrates the players and their respective roles in the service-based sales model. The roles of the provider may include: underwriting, product development, premium collection, administration, marketing, sales and providing the service. The provider may also contract an insurer to underwrite the insurance product.

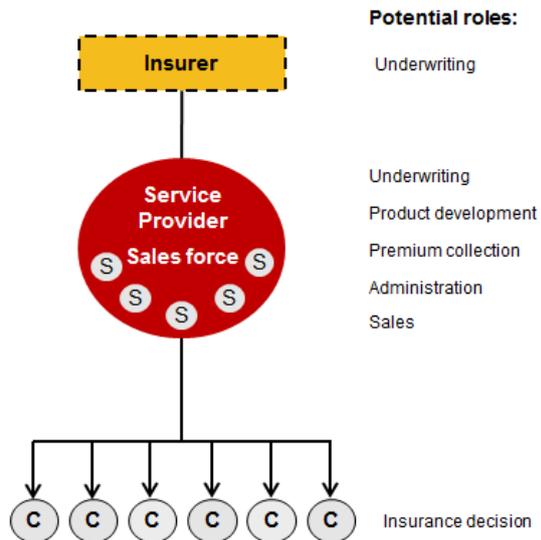


Figure 9: Service-based sales model

Source: Author's own

Examples

The primary examples of the service-based sales model are:

- Funeral parlours, which offer clients the option to pay a premium each month in return for the guaranteed provision of a funeral when they die.
- Hospitals, which may offer clients the opportunity to pre-pay for potential hospital visits.

Box 8: Example of service-based sales model

Grupo Vila - Brazil

Grupo Vila is a large, family-owned private cemetery and funeral home group of businesses operating in three states in the Northeast of Brazil. As part of its service package, it offers family funeral plans. Children of up to 35 years of age are covered, as are parents up to 65. The average premium is around R\$8-10 (USD \$3.84-\$4.80), covering a funeral service with an over the counter value of R\$2,500 (USD \$1,200). Funeral services on the plan are covered out of cash flow rather than from a separate risk pool. Sales are made through more than a hundred sales women selling door to door. To ensure that a consistent message is conveyed, a standard flipchart is used by all during discussions with prospective clients.

Apart from the cemetery and funeral services, Grupo Vila also runs medical clinics named "Multifam". The clinics were initiated to build customer loyalty: members of the Grupo Vila funeral plan receive discounted access to the clinics. In addition, plan members are informed of the availability of certain check-ups in the clinics during certain times (e.g. urological checks) at a discounted price. This is mostly used to attract customers, but can also be used as a proactive health management tool to reduce mortality in the risk pool (Bester et al., 2010).

Evolution

Latent client demand and service provider need for cash-flow. The trigger for the development of the service-based sales model is strong underlying demand for an essential service, which consumers

find that they cannot afford without insurance. This then prompts the service providers to, in some instances, pool risk in-house or, in other instances, source underwriting or sell the products of insurers in an agent capacity. Many service providers also have a particular cash flow need and the insurance premiums aid in maintaining consistent cash flows, thereby helping to financially establish the business. The model does not necessarily require a well-developed insurance sector to evolve, but can lead to various consumer protection risks (see Section 4.1).

2.3. Scenarios of evolution

The diagnostics reveal that the respective business models tend to evolve within specific sets of market conditions or circumstances. This section describes the five most typical market scenarios for the development of different business models²⁰:

Bottom-up development

Latent demand and insufficient commercial options result in creation of community-driven insurance products. In this scenario microinsurance evolves spontaneously on the back of underlying consumer needs and to fill gaps in formal provision. This scenario is typically the result of an underdeveloped formal retail insurance market, in which formal providers fail to appropriately cover the latent demand for risk mitigation within the community. The local self-help and service-based sales models tend to develop under these circumstances.

Market-making catalyst

Third party brings together insurer and intermediary. Under this scenario, the microinsurance business models are instigated by a party external to the insurer and aggregator. Both insurers and aggregators are comfortable in their traditional market segments, with limited capacity or incentive for expansion. A broker or administrator sees the opportunities for market making and matches insurers and aggregators or groups. The loyalty benefit auto-enrolment, group decision and proxy sales force models may all evolve in this way.

State-driven

The state as initiator. This scenario is applicable to the public provision aspect of the auto-enrolment model as well as to compulsory insurance, where the state is the driving force behind the evolution of the insurance offering. The state provides this insurance in order to meet specific policy objectives.²¹ Public provision can either crowd out private provision in the low-income end of the market, or it can leverage the market mechanism, thereby building capacity and triggering interest among private insurers to provide top-up cover or to reach parts of the market not provided for by public provision. Compulsory insurance can help stimulate the retail insurance market by compelling individuals to purchase the insurance.

Competitive dynamics

Competition in traditional market drives insurers down-market. Another scenario is where competitive market pressures and innovative players cause the market to "take on" the mass market challenge. This can lead insurers to work with third parties to implement alternative distribution.

²⁰ Note that more than one evolution scenario may play out together for different business models in a country.

²¹ Note that the state may also be involved in other models through a public private partnership, for example the group decision, individual sales or proxy sales force model. The state is however not the main driver behind the model.

Thus competitive dynamics, rather than community needs, external parties or the state, represent the main driver of insurance market development. This scenario can stem from competition either in the insurance industry or amongst potential aggregators such as MNOs wishing to provide additional benefits to subscribers in order to gain a competitive edge. Loyalty auto-enrolment, passive sales, proxy sales force, group decision and individual sales are all models that can evolve under the competitive dynamics scenario.

Commercial non-insurance drivers

In this scenario, insurance is initiated for one of three non-insurance commercial purposes:

- To mitigate financial risk for service providers such as credit providers (where insurance takes the place of collateral so as to remove default risk for the provider, should the client die or be unable to repay the loan for other reasons such as unemployment). Under this scenario, the primary beneficiary or initiator of the insurance is the service provider, which mitigates its risk by requiring clients to have insurance. As a result, the product may present relatively poor value to clients.
- To secure a market for the underlying services sold by the service provider, for example funerals and medical treatment where clients are unable to make single bulk payments to access the services.
- For aggregators, to add an additional revenue stream to their existing business and earn additional cash flow.

Embedded credit life and service-based sales would be models that evolve under this scenario.

3. Microinsurance business models: market dynamics

In this section we identify a number of market dynamics that characterise many of the microinsurance business models described in the previous section. These market dynamics may also be present in traditional insurance distribution, but are particularly pronounced in the microinsurance models. They therefore require different responses from insurance regulators and supervisors than traditionally contained in insurance regulatory frameworks.

The following seven dynamics are observed:

1. A number of non-insurance parties are involved in the insurance value chain;
2. Those selling the insurance may have reduced skills and training vis-à-vis traditional insurance brokers and agents
3. Those distributing insurance ancillary to another good or service may have misaligned incentives
4. Insurers have reduced bargaining power vis-à-vis those who control access to the clients
5. The combination of bargaining power and a longer value chain may mean increased distribution costs
6. Where a third party is the “face” of the insurance it may lead to increased reputational risk for the insurer
7. The nature of the target market may enhance consumer protection concerns

Below, the regulatory considerations arising from each issue are discussed in turn.

3.1. More non-insurance parties are involved in the insurance value chain

The microinsurance value chain includes a number of parties whose primary purpose is not the underwriting or distribution of insurance. This may be the case in the proxy sales force model, the group decision model, the auto enrolment model, the passive sales model and the service-based sales model. The long and complex value chain often found in microinsurance business models confronts insurance supervisors with more entities to consider in regulation. This requires supervisors to set entry and on-going requirements at a level that promotes provision of services by a broad spectrum of intermediaries, but in a way that does not undermine consumer protection. In doing so, supervisors may also be challenged by the fact that a number of parties are involved in the distribution of microinsurance that are neither licensed nor registered for their primary non-insurance duties/tasks by the insurance supervisor. The supervisor's authority is primarily over the entities which it licenses, which in such instances are the insurers. For example: mobile network operators are regulated by the telecommunications authority, where their regulation typically does not extend to distribution of financial services. There is usually no direct provision in the insurance regulatory framework for insurance distribution through such intermediaries. It may also be that other laws (e.g. banking regulations) do not allow entities under their jurisdiction, for example an MFI, to be an insurance agent.

The involvement of multiple parties gives rise to three main regulatory considerations:

- *Intra-agency coordination.* It requires the insurance supervisor to coordinate with regulators in other spheres, such as the telecommunications regulator, as well as with other financial sector regulators such as the central bank or the securities and exchange commission, so that the insurance supervisory objectives can be achieved in respect of entities that do not traditionally fall within the insurance supervisor's jurisdiction. An example of coordination between different regulatory authorities is when such authorities enter into formal memoranda of understanding to govern their interaction and cooperation in regulating a particular business model.
- *Accountability of entities.* It requires the insurance supervisor to make all involved in the distribution of insurance accountable to it for their insurance activities. That is, while the institutional regulation of non-traditional entities in the value chain will remain with the other respective authorities, the functional regulation of their role as participants in the insurance value chain needs to be incorporated under the jurisdiction of the insurance supervisor.
- *Supervisory capacity.* The demands placed on supervisory capacity by a multitude of additional distribution outlets (for example in a scenario where branches of microfinance institutions or mobile airtime vendors become insurance distributors) means that supervisors may need to delegate supervision of the sales force to insurers. Of particular concern are the skills and thus training needs of retail sales persons. Typically, this means that the insurer is held accountable for the actions of all persons selling its insurance policies. Insurers may be tasked with the compilation of a register of sales persons (sometimes described as microinsurance agents) and to train and oversee them, so as to ensure appropriate market conduct.

3.2. Reduced skills and competence of insurance salespersons

In the interest of consumer protection, distribution regulation usually requires a certain qualification or a minimum level of training and know-how for insurance intermediaries, although exceptions may be granted for mass distributed products.

Distribution by non-insurance aggregators reduces quality of sales process. Where proxy sales forces are used, or where insurer sales forces expand dramatically in line with new distribution models adapted, it means that the nature and quality of the sales force will differ from that of the traditional model of well-trained, qualified insurance brokers and agents. Even though microinsurance products are simpler and therefore require lower skills to sell, salespersons may still have insufficient knowledge and skills to sell such products. This dynamic is particularly pronounced in the proxy sales force model.

Ensuring appropriately informed customers without making requirements too onerous. For the above reasons, the traditional training, experience and qualifications requirements may be ill-suited to microinsurance. A resultant unintended consequence of regulation may be that sales persons are simply not licensed for insurance distribution purposes. Insurance supervisors therefore need to strike a balance in setting entry and on-going requirements for insurance distribution at a level that promotes provision by a wide range of persons, but at the same time ensures effective consumer protection.²²

3.3. Misaligned incentives for sales persons or channel

Disconnect between incentives of customer, aggregator and insurer. In the case of proxy sales forces, service-based channels, auto enrolment, passive sales and even group decisions, a third party, such as an aggregator, is inserted into the insurance sale, whose incentives are different from that of the insurer on the one hand, and the client's risk mitigation needs on the other hand. In the case of embedded credit life, for example, the primary incentive is to sell the credit rather than the insurance product. Likewise, a white goods retailer salesperson will primarily be interested in selling the underlying good, and will offer insurance in a way that promotes the sale of the underlying good. The motivations for the sales people of such third parties are also primarily aligned to that of the third party, underlying service or group, rather than the interests of the individual client. These different incentives tend to drive and condition the insurance sale, leading to potential distorted client perceptions and experience of insurance. It can also undermine the ability of the insurer to expand its delivery of risk products to the client.

Misaligned incentives may result in inappropriate policies. The scenario described above means that the channel is not primarily concerned about whether or not the particular policy is appropriate for the particular needs of the individual, whether or not the policy is renewed (or simply re-sold once lapsed) and how to disclose information in a way that is most likely to be understood by the client. Likewise, it may be in the third party's interests to delay paying over premiums to the insurer, at the risk to the consumer of being left without cover in the interim.

Elements of the traditional insurance regulatory framework, such as commission structures and disclosure requirements, may inadvertently reinforce misaligned incentives. For example: when an upfront commission structure implies that the sales person has no incentive to ensure policy renewals, where commissions are capped at a level that discourages an individual sales effort or ongoing servicing of the client post-sale, or where there are no appropriate disclosure requirements.

3.4. Reduced bargaining power of insurer vis-à-vis new intermediaries

Distorted bargaining power reduces value to client. Where the microinsurance value chain is based on partnerships between insurers and third party aggregators that provide access to the latter's

²² For example, India and Brazil have reduced requirements for the qualification of microinsurance agents.

client or member base (notably in the proxy sales force, auto enrolment, passive sales and group decision models, but also potentially in the compulsory insurance model and service-based sales model), it leads to a situation of unbalanced bargaining power, as the aggregator 'owns' the clients and can therefore demand substantial sums from the underwriter in exchange for exclusive access to the client base²³. This adds to the underwriters' costs, which is necessarily passed on to the consumer. In small markets where aggregators control a large market share (for example where only a handful of MNOs or formal retailer chains operate in the market) this risk is exacerbated, as the underwriter will not want to lose the partnership to a competitor. The result may be questionable consumer value in the form of low claims ratios. It can also lead to a sales situation where the best interests of the seller, rather than the client, enjoy priority, implying mis-sold insurance products.

The traditional insurance regulatory framework most often is tailored to a situation where the primary relationship is between the insurer and the client, not the client and a third party in respect of whom the insurance regulator does not have supervisory authority, and will therefore not allow for the new dynamics and power balance introduced by the emerging microinsurance distribution models.

3.5. Increased distribution costs

Long distribution chain increases costs. The combination of a long value chain, with more entities to remunerate along it, as well as the enhanced bargaining power of those parts of the value chain controlling access to the client base that is prevalent in most of the microinsurance business models may lead to increased distribution costs. Remuneration along the value chain is no longer purely broker or agents' commission, but may include administration, management or other service fees, amongst others. Where the nature of contractual arrangements between the various parties is opaque, tracking and controlling of levels of remuneration become difficult. This may inflate premiums or cause claims ratios to be disproportionately low.

3.6. Increased reputational risk for insurers

White-labelling can cause reputational risk. Due of the dominance of non-insurance interests and the new intermediaries involved, the insurer is often not the primary face of the insurance. This can lead to increased reputational risk, should an action of a channel participant lead to a mis-sold policy or result in clients not being aware of all terms and conditions. It will similarly undermine the reputation of the insurer, should the intermediary fail to pay over premiums or claims, resulting in lapsed policies or unpaid claims. Although this risk is not unique to microinsurance, it is enhanced within the access to insurance environment.

This consideration is mitigated when the brand interest of the aggregator/client owner, under whose brand the insurance is marketed, is a strong consideration in the channel. Associating the insurance cover with the brand of the channel means that the channel also stands to suffer reputational risk, should the insurance not deliver value.

3.7. Enhanced consumer protection concerns due to nature of target market

Nature of target market heightens the risk of consumer exploitation. The last market dynamic relates not to the nature of the distribution channel, nor to the value chain *per se*, but rather to the nature

²³ This situation is particularly potent in markets where insurers want to extend into new low-income market segments, but do not have developed agent networks.

of the target market. Typical microinsurance clients are less educated and have less knowledge and experience of insurance and financial services generally than the “traditional” upper-end insurance target market. This makes them more vulnerable to exploitation or mis-sold policies.

This can be exacerbated by the nature of the distribution process. The insurer is less visible to the client. Passive sales techniques or sales by persons with reduced skills or misaligned incentives will increase the risk of mis-selling where clients have limited knowledge and skills. Clients will be less aware of the fact that they have cover and of how to claim in the case of auto enrolment. Moreover, where clients have fewer resources to access consumer recourse mechanisms it will mean that independent or third party recourse mechanisms are less effective.

This requires supervisors to ensure that the sales process and the information disclosed during this process take into account the realities of the target market.

4. Consumer protection risks, risk drivers and observed responses

The business models each give rise to specific consumer protection risks. The microinsurance business models and market dynamics give rise to consumer protection risks that regulators must respond to. The risks are considered from the consumer protection angle as risks ultimately to the consumer rather than the insurer. *Though most of these risks are generic risks present also in other types of insurance,* the focus here is on the specific manifestation in microinsurance business models and based on the life cycle of the microinsurance process, that is, from product and service design, to the sales process, through to post-sale services. Six discrete risks arise:

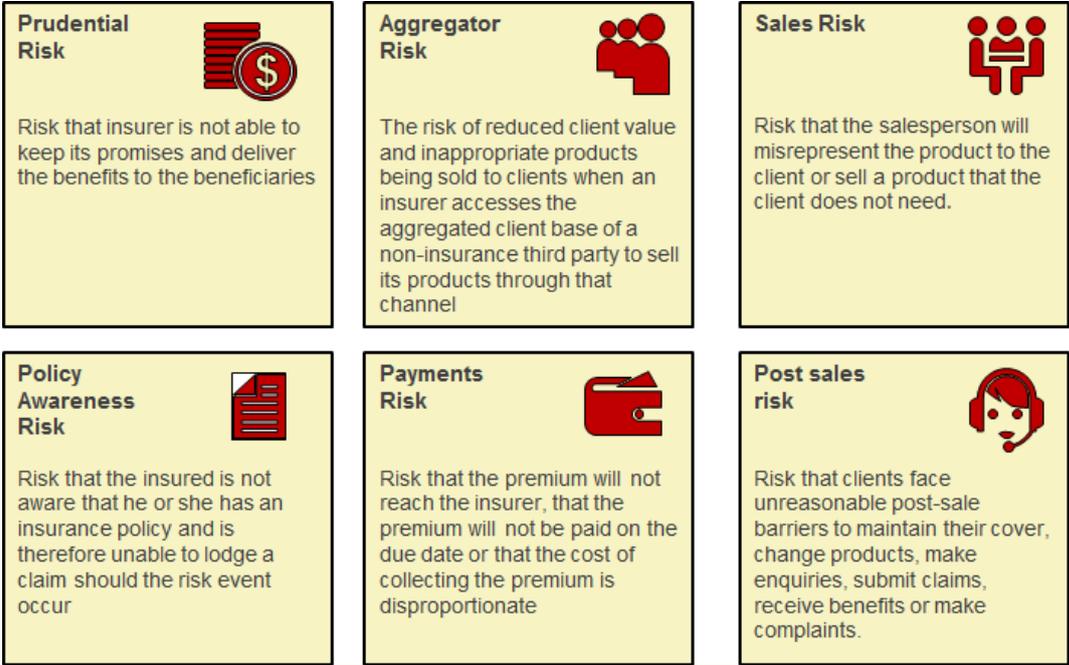


Figure 10. Introducing the microinsurance consumer protection risks

A number of underlying risk drivers. Each risk is the result of a number of drivers relating to the nature of the business models and the context within which they develop. This section therefore also looks at the underlying causes of the consumer protection risks that regulators should aim to mitigate. Some of these drivers relate to the market dynamics discussed in Section 3. In this section

we illustrate the manifestations of these dynamics and how they translate into specific risks to be addressed by supervisors.

Appropriate regulatory response. Finally, this section outlines observed and potential regulatory responses to each risk. In many cases there is more than one available response to a given risk and the supervisor will need to decide on which will be most appropriate. Any specific regulatory response may be inappropriate or appropriate, depending on the specific circumstances. The IAIS Application paper (2012: 4) highlights that supervisors should institute a proportionate response:

Supervisors need to adjust certain supervisory requirements and actions in accordance with the nature, scale and complexity of risks posed by individual insurers (i.e. the “proportionality principle”).

It is important to tailor supervisory requirements and actions so that they are commensurate with the risks posed by individual insurers to the insurance sector or to the financial system as a whole (IAIS, 2012).

Hence supervisors must be cognisant of contextual factors in the particular country, such as the overall regulatory approach, supervisory capacity, level of market development and the political and economic environment in order to identify which of these regulatory responses will be appropriate for which risks. The option of ‘do nothing’ as a response should also not be discounted in cases where a response cannot be appropriately implemented or may cause significant harm under current conditions.

Below, each risk is considered in turn.

4.1. Prudential risk

Prudential risk can be defined as the risk that the insurer as the risk manager is not able to keep its promises and deliver benefits to the beneficiaries²⁴. Prudential risk derives largely from the features of the insurer’s operations and management and therefore a lack of capacity of the insurer and a lack of regulation and oversight regarding the management of insurers heightens prudential risk.

Risk drivers. The main drivers of prudential risk are:

- Capacity of the underwriter, including risk management capacity, financial management capacity and product design capacity. A lack of capacity leads, amongst others, to the design of inappropriate products.
- Lack of supervision of the underwriter. This can result from the informality of the underwriter (it is not licensed and therefore not subject to supervision), or a lack of capacity of the supervisor.
- The underwriter is too small, particularly in relation to the size of the risk pool, to efficiently pool risk, making the insurer prudentially vulnerable to large individual claims.
- Inadequate corporate governance, leading to inadequate oversight over internal risk management processes.
- Lack of actuarial data for the particular target market to enable sound pricing.

²⁴ See for example the 2007 IAIS-MIN Issues Paper in Regulation and Supervision of Microinsurance. Available at: http://www.iaisweb.org/view/element_href.cfm?src=1/2495.pdf

All of these factors can increase the risk of the insurer becoming financially unsound and therefore unable to meet its contractual obligations to its clients.

Business models in which risk is most prevalent. Though present in all models, prudential risk is particularly evident in the compulsory sales model, the local self-help model and the service-based sales model:

- **Compulsory insurance:** As the insurance product is compelled by legislation in the compulsory insurance model, it can be highly lucrative for insurers. This can encourage insurers without the requisite prudential capacity, and sometimes with fraudulent intent, to offer the product despite the risk of failure. This places clients’ policies at risk of being reneged on.
- **Local self-help:** In the local self-help model the risk is pooled internally by the group without engaging the services of a commercial insurer. Where a lack of capacity leads to poor risk management practices, this can create significant prudential risk. Likewise, a change in the risk profile of members (for example higher than expected mortality), may undermine prudential soundness.
- **Service-based sales:** In cases where the service provider, for example a funeral parlour or a medical facility, retains the risk informally rather than obtaining underwriting from a licensed insurer, significant prudential risk is created due to lack of specialised insurance experience and capacity, as well as the absence of supervisory oversight.

Observed responses. The following responses have been observed across jurisdictions to each driver of prudential risk in the inclusive insurance sphere:

Risk driver	Observed responses
Capacity of the underwriter	Introduce product restrictions to reduce prudential risk, for example benefit or premium caps, term restrictions, restrictions on risks that may be covered, prescribing specific pricing formulas, or restricting who can be insured.
	Require prior approval of products by the supervisor to check the actuarial soundness of pricing.
	Lower entry and compliance requirements for underwriters (tiering or concessionary approach), while retaining a minimum entry requirement to preclude entities that are too small. This response is primarily intended to entice informal entities into formal supervision.
Lack of supervision of the underwriter	Institute simplified but regular reporting to the supervisor.
The underwriter is too small	Legislate a minimum threshold for the size of the risk pool covered by the insurer.
Inadequate corporate governance	Require entities underwriting risk to separate the insurance underwriting from other business activities.
	Institute minimum corporate governance requirements.

Table 3: Prudential risk - observed responses

4.2. Aggregator risk

Aggregator risk is the risk of reduced client value and inappropriate products being sold to clients when an insurer accesses the aggregated client base of a non-insurance third party to sell its products through that channel.

Risk drivers. Cross-country evidence suggests that at least three factors lead to aggregator risk:

- Disproportionate bargaining power in favour of the aggregator vis-à-vis the insurer where the former owns the clients through a prior business relationship. This bargaining power enables the aggregator to extract disproportionate remuneration for providing access to the client base. Limited availability of mass distribution channels in a particular market may mean that insurers compete for the business of a few large aggregators. This increases the relative bargaining power of the aggregator.
- The dominant position of the aggregator vis-à-vis the client can influence the purchasing decision of the client due to the pre-existing relationship between them. This is especially prevalent in the relationship between a loan client and a credit provider. In order to access the loan, the client has no choice but to take out insurance and, even if he or she technically has a choice of insurance option and provider, is prone to accepting the option and conditions provided by the credit provider.
- Products are designed to address the financial risks and interests of the aggregator as opposed to that of the client. This happens where the aggregator's rationale for entering into an insurance partnership is, for example, to protect itself against default risk; to increase its revenue by creating secondary revenue streams; or to enhance client loyalty by tying the client more strongly to them through additional service offerings. In each of these instances, the focus of the product design is on the interests of the aggregator rather than the client.

All of these factors can lead to reduced client value or to inappropriate products being sold to clients.

Business models in which risk is most prevalent. Aggregator risk is a key differentiator in the proxy sales force model and the group decision model:

- **Proxy sales force:** As sales are made through a proxy sales force situated in a third party aggregator, there may be misaligned incentives between the aggregator, the insurer and the client. The insurer has an incentive to properly inform a customer of a product at the point of sale in order to increase persistency and reduce churn, whereas a sales intermediary simply has an incentive to maximise sales as a secondary concern to the sale of their primary good or service. As the insurer does not have direct oversight over the sales force, it cannot easily align the incentives of the sales force with its own. Furthermore, it can result in products that are designed to primarily address the aggregator's needs rather than that of clients. The presence of an additional intermediary between the client and insurer also increases the disconnect between the client and insurer.
- **Group decision:** As with the proxy sales force model, the additional entity between the insurer and the end-client creates the possibility of misaligned incentives and inadequate communication.

Observed responses. Potential regulatory responses to each aggregator risk driver observed across countries include:

Risk driver	Observed responses
Disproportionate bargaining power of the aggregator vis-à-vis the insurer	Institute caps on aggregate distribution costs (commission, marketing, administrative and other costs combined). This limits the extent to which the aggregator can demand payments from insurers to access their distribution channel.
	Require disclosure of the contract between the insurer and the aggregator to the supervisor.
	Impute by law a direct insurance relationship between the insurer and the insured irrespective of any contractual relationship between the aggregator and the client.
	Mandatory disclosure of commission and cost structure to the client.
The dominant position of the aggregator vis-à-vis the client	Prohibit the credit provider from requiring the borrower to enter into an insurance policy with a specified insurer, that is, the client must be provided a choice of insurer even though the insurance policy may be mandatory.
Financial risks and interests of the aggregator are addressed as opposed to the client's	Mandatory reporting of claims ratios and expense ratios to the supervisor in order to monitor the relative value that is being delivered to clients.
	Require public disclosure of comparative statistics on distribution costs by the supervisor (transparency rules), so that clients can monitor whether a given insurance policy offers appropriate value.
	Require the prior approval of products (for example through a "file and use" system) by the supervisor to ensure that certain client value parameters are met.

Table 4: Aggregator risk - observed responses

4.3. Sales risk

Sales risk is the risk that the salesperson will misrepresent the product to the client or sell a product that the client does not need. Reduced client value or inappropriate product choice can also be the result of sales risk.

Risk drivers. Sales risk arises when:

- Sales persons have insufficient knowledge and skills to sell insurance products of the kind sold to the target market.
- Incentives for the salespersons are misaligned with the interests of the client, for example: there is no incentive to ensure policy renewals where the salesperson only receives an up-front commission; commissions are capped at a level which discourages sales effort; or the incentives are to sell the product or service in which the insurance is embedded (such as credit) or to which it is linked (such as a white good in the case of extended warranties) rather than the insurance product.

- There is inadequate accountability of sales persons. Limited oversight of salespersons increases the likelihood of them misrepresenting the insurance product to potential clients in order to make the sale.

These factors all increase the possibility of insurance policies being misrepresented to clients during the sales process.

Business models in which risk is most prevalent. Sales risk arises primarily in the individual sales model, the proxy sales model, the passive sales model and the service-based sales model:

- **Individual sales:** Where agents or brokers receiving upfront commission push a sale to earn commission, knowing that any recourse by the consumer will be at best delayed, there will be an incentive to misrepresent the product or not to spend sufficient time explaining the terms and conditions.
- **Proxy sales force:** Since these salespersons are employed in the first instance to sell non-insurance products, their professional training and skills are not focused in the insurance space. It is easy for conflicts of interest to arise, depending on the relative remuneration of their insurance sales vis-à-vis their normal sales.
- **Passive sales:** As the sale is initiated by the client and there is no direct face-to-face interaction between a seller and the buyer, the policyholder’s understanding of the policy he or she is purchasing may not be sufficient.
- **Service-based sales.** The primary focus of the service provider in the service-based sales model is not on insurance but rather on the underlying service it provides. Its sales personnel may therefore misrepresent the insurance policy to potential clients due to limited training and knowledge or in an effort to promote the underlying service.

Observed responses. The observed regulatory responses to sales risk across countries include:

Risk driver	Observed responses
Sales persons have insufficient knowledge and skills	Minimum qualification and training requirements (including both the length and content of training) for sales persons, often tailored to a dedicated microinsurance agent category.
	Implement a file and use requirement for mass communication materials proposed to be used by the insurer. This allows the supervisor to require the insurer to change or withdraw any misleading or false communication.
	Make insurers liable/ responsible for all the actions of their intermediaries as if the latter were their employees, thereby creating an imperative for insurers to monitor their distribution partners’ conduct.
Incentives for the salespersons are misaligned with the interests of the client	Permit uncapped commissions so that agents have sufficient incentive to make each sale ‘properly’ (but monitoring commission levels to ensure that they do not undermine client value).
	Implement a mandatory structuring of commissions to include both an upfront and an “as and when” component so that agents are incentivised to service clients also post-sale.
	Implement a prescribed code of conduct for (microinsurance) sales persons that details explicitly how sales should and should not be conducted.

Risk driver	Observed responses
	Legislate product simplification requirements, for example plain language and limited exclusions.
	Require a statutory cooling off period during which the insured can withdraw from the insurance contract. This mitigates the risk of mis-selling.
Inadequate accountability of sales persons	Require explicit disclosure requirements, that is, minimum terms and conditions to be disclosed to the client verbally and/or in writing, often linked to a requirement that it be done in the client's vernacular.
	Require a mandatory complaints resolution procedure to be maintained by the insurer (usually at its own cost rather than on a user charge basis) with or without minimum performance standards for the complaints resolution process.
	Implement explicit registration requirements for sales persons. Sometimes the registration obligation is delegated to the relevant insurer, with a reporting duty to the supervisor.
	Make the insurer directly accountable for all the actions of the intermediary.

Table 5: Sales risk - observed responses

4.4. Policy awareness risk

Policy awareness risk is the risk that the insured is not aware that he or she has insurance cover and is therefore unlikely to lodge a claim, should the risk event occur. The manner in which insurance is sold through certain microinsurance business models can heighten the risk that policyholders are unaware that they have insurance coverage.

Risk drivers. Three key drivers of this risk arise across countries:

- The absence of a specific sales action, for example in the case where clients are auto-enrolled. No action is required by the insured individual in order to be covered. This reduces the likelihood that they are aware that they are covered and what the level and nature of the cover is.
- A “tick box” sales process where clients fill out an application form for a financial service or other product which is sold with the insurance by literally ticking boxes on a form (or responding to simple verbal questions when sales are through a call centre), without the terms and conditions being explained to them.
- Low level of financial literacy on the side of the client increases the likelihood that they will be unaware of their insurance cover.

The presence of each of these factors increases the likelihood that the client will be unaware of their insurance coverage.

Business models in which risk is most prevalent. Policy awareness risk is a particular feature of the proxy sales force model, the compulsory sales model, the group decision model and the auto enrolment model:

- **Proxy sales force:** The proxy sales force model includes mandatory or embedded products. In such cases, there is a heightened risk that the insured individual may be unaware they have the insurance cover since their focus in the sales process is on the main product or service (such as credit) that they are purchasing.
- **Compulsory insurance:** The compulsory nature of the insurance means that clients are mandated to purchase it. Where the premium is for example deducted directly by an employer (such as in the case of mandatory social health insurance), the individuals may be unaware that they have cover. It also makes the client less engaged in the on-going maintenance of the policy.
- **Group decision:** In the group decision model, individuals are covered by virtue of being members of the group. Where they are enrolled into the policy without their explicit knowledge or participation, for example through a decision of the decision-making body or leadership committee of the group, the risk arises that they will not claim or benefit from the policy.
- **Auto enrolment:** As the policyholders are automatically enrolled into the policy there is a significant risk that they will be unaware of the policy and hence will not claim or benefit from it.

Observed responses. The observed responses to policy awareness risk across jurisdictions include:

Risk driver	Observed responses
The absence of a specific sales action	In cases where there is auto enrolment, such as public provision, move from a fully publicly funded to a part contribution system, so that the insured pays part of the premium, even if only a token part. In this way, the insured individual becomes aware that they have the insurance cover.
“Tick box” sales process	Require post-sales communication to the insured within a specified period, for example 30 days, from the date on which he or she entered into the insurance policy (especially relevant for embedded products). This helps to ensure that the insured individual is aware of the terms and conditions of the insurance cover.
	Require mandatory choice between multiple insurers in the case of compulsory products to make the insurance sales process more explicit to the client.
	Require a statutory cooling off period during which the insured can withdraw from the insurance contract. This mitigates the risk of mis-selling.
Low level of client financial literacy	Implement a dedicated communication campaign targeting the insured population or build client education elements into the sales/disclosure process..

Table 6: Policy awareness risk - observed responses

4.5. Payments risk

Payments risk is the risk that the premium will not reach the insurer, that the premium will not be paid on the due date or that the cost of collecting the premium is disproportionate. Payments risk means that there is a heightened possibility that premiums are not regularly received by the insurer, leading to policy lapses.

Risk drivers. The salient drivers of payments risk are:

- The presence of an intermediary between the insurer and aggregator or client who can delay payment of the collected premium to the insurer or neglect to make the payment at all.
- Seasonal or irregular income of clients, which causes them to miss monthly or other set dates for premium payments. Where they are not aware of the repercussions of missing premium payments, this may create consumer protection risks.
- Mandatory payment system requirements that apply to premium collection, for example that it has to be paid through a bank. This may increase the cost and difficulty for clients to make premium payments, thereby increasing the likelihood of lapsed policies and late premium payments.

These factors increase the possibility that premium payments are not regularly received, implying that the client may not be covered, or increase the cost of premium collection, which may erode client value.

Business models in which risk is most prevalent. The business models in which payments risk is most prevalent include the individual sales model, the proxy sales force model and the group decision model. In all three instances, the intermediary or entity between the insurer and the client may collect premiums, which creates the risk that premium payments will not reach the insurer timeously²⁵. The risk is less prevalent for the other models, as they either involve the client paying premiums to the insurer directly, or entail a single group premium. In the case of the local self-help model and informal service-based sales, no premium is paid over to an insurer or a single premium is paid over by the service provider.

Observed responses. Various regulatory responses to payments risk have been observed across countries. These include:

Risk driver	Observed responses
The presence of an intermediary between the insurer and aggregator or client who can delay payment of the collected premium to the insurer	Stipulate the maximum period within which the intermediary collecting the premiums must pay them over to the insurer.
	Require financial soundness of intermediaries and require that collected premiums are ring-fenced, for example in a separate trust account.
	Require that the receipt of the premium by the intermediary is imputed as the receipt of the premium by the insurer.
Seasonal or irregular income of clients	Legislate a statutory grace period (during which cover remains in place) if the premium is not paid when due. The length of the grace period can be made proportionate to how long the policy has been maintained.
	Require that insurers allow more flexible premium collection options/ payment system options ²⁶ .
	Regulate the structure of payments to facilitate irregular or lump sum payments.
Mandatory payment system requirements	Allow for premium payments in cash or through non-bank payment systems and outlets, and design the necessary safeguards in this regard. Premium payments are

²⁵ Note that the arrangement may also be that the insurer collects premiums directly, for example via a bank debit.

²⁶ It is also important that the central bank allows flexible payment system options and the infrastructure is in place.

Risk driver	Observed responses
	often below a stated amount ²⁷ to avoid AML/CFT requirements.

Table 7: Payments risk - observed responses

4.6. Post-sales risk

Post-sales risk is the risk that clients face unreasonable post-sale barriers to maintain their cover, change between products, make enquiries, submit claims, receive benefits or make complaints. It therefore refers to the risk of poor service and the potential disincentive for insurers to be efficient in claims processing and service provision.

Risk drivers. Seven major factors have been identified to drive post-sales risk across countries:

- Clients with limited knowledge and experience of insurance are unaware of the process and requirements to submit a successful claim.
- Lack of reasonable access to the insurer or the intermediary after the sale (low-income clients prefer personal contact - a person or a branch to go to).
- Faceless insurers (from the client’s perspective) who underwrite policies distributed by third parties. This creates a greater separation between the insurer and the client, particularly from the client’s perspective, making it more difficult for the beneficiary to engage with the insurer in order to claim.
- Unscrupulous insurers who are intent on rejecting or delaying claims. This happens notably in countries with compulsory insurance, coupled with inadequate supervision, but can occur in any model in any jurisdiction. Another possible manifestation of this risk driver is where players impose unreasonable claims documentation requirements or “hide” requirements in fine print. This increases the difficulty and cost for beneficiaries to claim and reduces the proportion of successful claims, thereby reducing the value of the product to clients.
- Onerous claims documentation requirements. Even if documentation requirements are not unreasonable, they may still be onerous for clients to meet. In some countries, for example, it may be difficult or costly, or take a long time, to obtain a death certificate, police accident/theft report or adequate proof of medical expenses. This may undermine the ability to lodge a successful claim.
- The manner in which group underwriting is done, notably when there is selective non-renewal of individual group members’ cover by insurers. This allows insurers to only insure those individuals with the least risk, undermining the concept of pooling the group’s risk.
- Incidence or past history of monopolistic insurance provision. An insurer with greater market power will be able to offer poorer after-sales service and still retain the client due to the lack of alternative options available to clients.

Each of these factors heightens the risk that insurers will not deliver appropriate and valuable post-sales service to their clients, or that clients will face barriers to claim successfully.

²⁷ Dependent on individual countries regulations

Business models in which risk is most prevalent. The individual sales model, the proxy sales force model, the compulsory sales force model, the auto enrolment model and the passive sales model are all particularly vulnerable to post-sales risk:

- **Individual sales:** Where an intermediary earns only upfront commission, there will be little incentive to provide post-sales service as they have already collected the revenue.
- **Proxy sales force:** As the sales force is separate to the insurer and has different incentives to it, there is a separation between the sale of the policy and the underwriting and administrative functions.
- **Compulsory insurance:** There may be limited incentive for the service provider/ insurer to provide post-sales services where they are guaranteed a market in that clients are compelled by regulation to purchase the product.
- **Auto enrolment:** The lack of awareness of the policy and presence of subsidised or fully sponsored premiums in the auto enrolment model means that the insurer may feel there is less chance of complaints from the insured in the event of poor post-sales service.
- **Passive sales:** Due to the lack of an active sales process and no “go to” person or entity, clients may be less likely to avail of post sales services or to know where and how to access such services.

Observed responses. The observed responses to post-sales risk across jurisdictions are:

Risk driver	Observed responses
Clients with limited knowledge and experience of insurance	Implement public consumer awareness and education campaigns. A greater awareness and understanding of insurance and how it works would allow clients to better navigate the claims process.
Lack of reasonable access to the insurer or the intermediary after the sale	Require that insurers maintain client recourse systems with or without minimum performance standards.
	Require that microinsurance complaints are in the first instance directed at insurers; only if the insurer does not satisfactorily resolve the complaint is it then referred to an independent recourse channel such as an ombudsman or the supervisor.
	Require clear communication (verbally and/or in writing) of available recourse mechanisms to the client, including the identity of the underwriter where policies are branded under the name of the distribution partner.
	Prescribe what documentation may be required by an insurer to settle a claim (for example, that it shall be kept to a minimum or be limited to specified documents).
Faceless insurers (from the client’s perspective) who underwrite policies distributed by third parties.	Register and train salespersons. Using salespersons in the sales process puts a face and access point to the insurer for the client
	Require structuring of commissions to include an as and when component to encourage the intermediary to maintain a face vis-à-vis the client.
Unscrupulous insurers	In the case of service-based sales, require insurers to provide the option of a monetary benefit instead of an in-kind benefit. This prevents the insurer from supplying a sub-standard, and cheaper, service than the promised monetary value thereof.

Risk driver	Observed responses
	Prohibit or limit deductibles in microinsurance policies. This helps to preempt insurers adding hidden costs or excesses
	Stipulate the maximum periods for claims processing and claims payments, forcing insurers to honour claims timeously.
Manner in which group underwriting is done	Prohibit selective cancellation of individual cover within a group policy except in cases of deliberate attempts to defraud the insurer.
Incidence or past history of monopolistic insurance provision	Liberalise the insurance market to increase competition and options for clients.

Table 8: Post sales risk - observed responses

4.7. Risk profiles of the different business models

The structure of each of the business models identified in Section 2.2 leads to different risks. As the discussion above showed, the specific characteristics of each of the models, such as the number of entities involved in the value chain and each player's specific incentive structure, lead to different risks being more prevalent in different models. Though most risks are to some extent present in all the models, the matrix below summarises the *most prevalent* risks for each specific business model:

	Prudential risk	Aggregator Risk	Sales Risk	Policy Awareness Risk	Payments Risk	Post Sales Risk
Individual sales			X		X	X
Proxy sales		X	X	X	X	X
Compulsory sales	X			X		X
Group decision		X		X	X	
Local self-help	X					
Auto enrolment				X		X
Passive sales			X			X
Service-based sales	X		X			

Table 9: Risks per business model matrix

Source: Authors' own

This matrix presents a unique risk-skew profile for each of the business models, a further distinguishing feature between them. This analysis can be used as a practical device by supervisors to determine which risks are likely to be most significant within their jurisdictions, based on which business models are most prevalent within the market.

5. Conclusion

This paper identifies eight discrete microinsurance business models, classified primarily by distribution channel. These business models give rise to cross-cutting microinsurance market dynamics that can create regulatory concerns on a number of fronts. From these business models also arise specific risks, each the result of a number of risk drivers that supervisors need to manage in

order to protect consumers. This requires a proportionate response by supervisors in line with the IAIS Application Paper on Regulation and Supervision Supporting Inclusive Insurance Markets.

The regulatory responses listed in this paper represent the full gamut of observed responses across countries. In many cases there may be more than one appropriate response to a given risk and the response chosen will depend in large part on the overarching regulatory approach and other external factors present in the specific jurisdiction. The different regulatory approaches, their triggers and impacts are discussed in Paper 2.

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Hosted by GIZ Sector Project Financial Systems
Approaches to Insurance
Gesellschaft für Internationale
Zusammenarbeit (GIZ)
Dag-Hammarskjöld-Weg 1-5
65760 Eschborn, Germany

Telephone: +49 61 96 79-6466
Fax: +49 61 96 79-80 6466
E-mail: info@access-to-insurance.org
Internet: www.access-to-insurance.org

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