



Volume III, No. 11

Journal

OCTOBER 2005

**BACK
TO THE**

BASICS

बीमा विनियामक और विकास प्राधिकरण



Volume III, No.11

Journal

OCTOBER 2005

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Editor:

K. Nitya Kalyani

Hindi Correspondent:
Sanjeev Kumar Jain

Design concept & Production:
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Editor: K. Nitya Kalyani

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Hyderabad 500 004
Phone: 5582 0964, 5578 9768
Fax: 91-040-5582 3334
e-mail: irdajournal@irdaonline.org



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From the Publisher

The last few years saw private sector competition enter the field and the impressive growth of the industry is due to contribution from both private and public sector companies who have succeeded in enlarging the market.

The tariff has mostly protected the non-life companies from the adverse impact of competitive forces. Over the decades it has created a system of cross subsidies and it now needs to be removed in order to give the industry a fair opportunity to attain commercial success in a competitive market place. This will pave the way for a healthy industry that serves the needs of the consumers at a fair price and with sustainable profitability for itself.

One of the basic internal needs for competitive and appropriate pricing of insurance is the technical skill of underwriting. That is what this issue of **IRDA Journal** explores. In our context the industry has to virtually return to underwriting since it has, for a few decades, relied on tariffs and has largely lost the skills to evaluate individual risks and price them correctly.

The most significant external requirement of a market moving from an administered price to free

pricing is good sequencing and monitoring by the Regulator so that the market remains as stable as possible and the end customers' interests are protected even if there is a disturbance. That is what the Authority has been working towards by creating a road map where the various milestones are identified for different activities so that the Authority can monitor the transition from administered pricing to risk based pricing.

In early September we had occasion to welcome into the Authority the new Member (Non-Life), Mr. K. K. Srinivasan, who brings with him rich experience in matters technical and legal from the industry and, most recently, from the Tariff Advisory Committee (TAC). He will be guiding the detariffing process on a day to day basis. We extend a warm welcome to him through this issue of the Journal too.

The next issue of the Journal will profile some of the social security schemes available in the country which are in the nature of insurance. This will serve to give us an understanding of the nature and scope of the security net that the country requires in our quest for financial stability and security for our people.

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C.S.RAO

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The Core Function

Times change, and force us to change with them if we are to thrive.

In that context, the insurance industry is on the verge of coming a full circle from its circumstances in the 1950s. A private sector dominated industry was nationalised in the aftermath of a shakeout caused by some companies with commercially minded underwriting and consequential financial weakness and slack customer service.

The nationalised industry consolidated its network and financials admirably but, inevitably, the lack of competition led to stagnation, and customer service hardly took its place in the sun. Liberalisation introduced competition in the industry with the advent of private sector companies promoted by Indian and foreign business groups. In a logical progression towards enhancing market competition for consumer value, we are now moving towards dismantling the administered pricing system that governed most of the general insurance business for about four-and-a-half decades.

Pricing of general insurance products is a continuous process of learning. Tracking current developments is important to recognising and evaluating risks and to pricing them. Sound basics ensure a strong financial foundation for the company which is exposed to stupendous losses in cases of catastrophes of the natural, manmade or even the legal liability variety.

It is with this in view that we bring you a collection of articles in this issue of how the industry needs to find its way back to sound underwriting practices. The issue comes to you at a time when IRDA has published its roadmap to detariffing the industry by December 2006.

To introduce the writers in this issue, some of whom you will be meeting here for the first time:

Mr. P. C. James, Executive Director (Non-Life), IRDA writes about how underwriters uphold the interests of all stakeholders. Mr. Arun C. Chaubal, who served in the public sector general insurance industry and is now Managing Director, BMS India Intermediaries Pvt. Ltd., tells us about the need for 'hard' and 'soft' skills while underwriting in a detariffed environment.

Mr. V. Ramakrishna, Managing Director, India Insure Risk Management Services (P) Ltd., outlines how a broker can be a key link in the underwriting process while Dr. Rajeshree Parekh, an ophthalmologist who heads the Employee Benefits operations of Marsh India Pvt. Ltd., presents a practitioner's view of the basics of group insurance underwriting.

We bring you the third and concluding part of the paper based on the research study of Medclaim conducted at National Insurance Company by Ms. Indrani Gupta, Professor and Head of the Health Policy Research Unit, and Mr. Mayur Trivedi, consultant at the same institute.

Our next issue will profile some of the social security schemes that we have in India to form an idea of the nature and scope of the benefits and coverage that were devised in the past and protected thousands of families through financial difficulties.

K. Nitya Kalyani



The Safety Net

K. Nitya Kalyani

Pooling resources is a common and effective solution for protection against potential losses. Such pools are quite well known in the context of employer-employee relationships, more so where the employee group is large, and most certainly where the Government is the employer.

Employer-run retirement schemes, which are also sometimes funded by the employer, include provident funds and pensions, benefit schemes related to healthcare expenditure, retirement investment schemes and more. These are all present in India in various forms and are mandated by different laws.

The importance of such schemes, as well as their current inadequacy in addressing the society's requirement, are illustrated by some numbers.

Of about 400 million workers, only about 35 million are in the organised sector, which is covered by such schemes. These are 1999-2000 figures published by the Ministry of Labour and more disturbing is the fact that in the previous 10 years, while the total labour force grew by 55 million, that in the organised sector grew only one million.

Stopping a moment to define the sectors: The organised sector includes primarily those establishments which are covered by the Factories Act, 1948, the Shops and Commercial Establishments Acts of State Governments, the Industrial Employment Standing Orders Act, 1946, etc. This sector already has a structure

through which social security benefits are extended to workers covered under these legislations.

The unorganised sector, on the other hand, is characterised by the lack of labour law coverage, seasonal and temporary nature of occupations, high labour mobility, dispersed functioning of operations, casualisation of labour, lack of organisational support, low bargaining power, etc., all of which make it vulnerable to socio-economic hardships.

Needless to say, the latter requires

Employer-run retirement schemes, which are also sometimes funded by the employer, are present in India in various forms and are mandated by different laws. The importance of such schemes, as well as their current inadequacy in addressing the society's requirement, are well illustrated by the numbers.



social security even more than the former and this has been discussed in many forums widely.

The scope of the existing schemes is

large. For example, the Employees Provident Fund Organisation (EPFO) covers over 3,93,824 establishments, has over 3.9 crore members and has a corpus (with its related schemes) of about Rs. 1,39,000 crore. This works out to about a third of the invested funds of the life insurance industry, which was about Rs. 4,18,000 crore at the end of the last financial year. And one must remember (see above) that this coverage extends at best to eight to nine per cent of the working population of the country.

Retirement schemes like the now closed Varishtha Pension Bima Yojana were floated to address specific needs and to protect retired people in a falling interest rate market. Postal Life Insurance, well over a 100 years old, is a closed insurance system for employees of government departments and undertakings.

In the next issue of *IRDA Journal* we will profile some of these initiatives that include the Employee State Insurance Scheme (ESIS) and Postal Life Insurance and try to see what can supplement the social financial stability they stand for and how.

The subsequent issue of the *Journal*, of December 2005, will be our third annual issue. We would like to discuss how consumer protection works in the insurance industry and in other financial services industries, too. Any suggestions on how to approach the topic as also contributions in the form of articles are welcome. Please mail us at irdajournal@irdaonline.org.



Welcome!

It's been a natural transformation for Mr. K. K. Srinivasan who took over as Member (Non-Life) at IRDA in early September. From being the guardian of the Tariff in his capacity as Secretary of the Tariff Advisory Committee (TAC) for four years, he now facilitates its dismantling! For within days of his joining the Regulator's office, a roadmap to guide the general insurance industry to go off the tariff has been circulated.

"Detariffing by itself will be a great challenge to the industry and the Regulator," says Mr. Srinivasan who, in 1969, joined The New India Assurance Company, when it was still in the private sector, as a management trainee. The significance of this roadmap is the clear and achievable deadline and the milestones that the companies have to accomplish. "All the companies are of good standing and sound lineage and they will complete this as it is a matter of their reputation," he says.

What replaces the tariff rates has to be well thought out, he says, and each company has to finalise internal guide manuals and integrate them into their underwriting systems.

Moreover, the roadmap is a guide to enable a smooth process rather than a tool to punish transgressions, as he puts it, just as the regulations are a way of setting minimum standards for the industry to live up to.

"But a word of caution: regulating an industry is like patrolling vast unfenced frontiers. No matter what level of vigil you exercise, there will be breaches. But that should not stop you from being vigilant and invite disaster. One should also not have over-regulation and stymie development," he says.

The industry is itself in a critical stage of development, according to him, when it has moved into the consolidation phase after a period of development from a regulatory perspective. "It is in this stage that companies, having reached a particular stage and speed of growth, launch themselves into aggressive growth. There will be a temptation to cut corners and the

Regulator has to intervene in such a way that while unhealthy practices are discouraged, healthy growth is not inhibited," he observes, adding that there has to be in place an appropriate system to monitor market conduct.

In this context and that of detariffing, Mr. Srinivasan stressed the growth phase that the intermediaries will go through. Brokers and corporate agents, TPAs and surveyors, will all be tested in their technical knowledge and service levels. While some will grow into the role of providing expert service, others who do not measure up will fall by the wayside and there will be a shakeout in the market, he predicts.

Hence, it is important that the intermediaries' regulations too be carefully reviewed periodically and possible changes made incorporating corporate governance norms for them.

He foresees larger and larger areas of regulation passing from the hands of IRDA to those of self-regulatory organisations (SROs), chiefly the General Insurance Council, which also has to quickly reach the form intended for it to carry out this important function.

It is interesting, he says, that the TAC started out initially as an association of insurers who voluntarily took the tariff as binding while at the same time the market had non-tariff companies also. It was in the 1968-69 period after the social control measures that the TAC became a statutory body and the tariffs framed were binding on all insurers.

Today, it is on the threshold of coming a full circle and becoming a voluntary body again, and will serve as



a data repository for the industry and IRDA and provide technical guidance.

Mr. Srinivasan, who has moved from Mumbai to Hyderabad for his new role, is still settling down in the new location. His wife, a school teacher, will look to continuing her work with a new school and his young daughter is coping with moving schools mid-year.

A reading and Yoga fanatic, he admits he has missed out on the latter in the past couple of years and guiltily says he needs to get back to it!

The reading has never been abandoned though! His recent favourite was President Dr. A. P. J. Abdul Kalam's biography, *Wings of Fire*, which inspired him with its lesson of how a person of humble beginnings can reach heights through sheer aspiration to excel and hard work. "It is a must-read for people of all ages as it encapsulates, in simple words, all the wisdom so glamorously stated in management books," he says.

He continues to be a fan of the management books as well as the thrillers, though! His all time favourite read? Peter Drucker's entire body of writing and, in particular, *Management Challenges for the 21st Century*, the book he wrote in 2000 in his 90th year.

"The book outlined the role India would play in the years to come and it has all been coming true in the last five years," he says happily.

Only Equity Shares, says IRDA

IRDA has clarified to all the insurers, reinsurers and intermediaries that they may issue only equity shares and not preference shares or any hybrid instrument against their share capital. It has also reiterated that transfers of shares, (including through renunciation of rights) amounting to five percent or above to any other entity (2.5 percent if the other entity is a banking or an investment company) shall be done only with the previous approval of the Authority.

The circular dated August 25, 2005, addressed to insurers, the reinsurer and all intermediaries, reads as follows:

Re : Regulatory framework on (i) issue of shares in any form other than equity and (ii) transfer of shares

i) Issue of shares in forms other than equity

We invite your attention to the provisions of Section 6A of the Insurance Act, 1938 which lays down the requirements as to the capital structure of insurance companies. The Section provides that no public company limited by shares shall carry on life insurance business unless its paid up capital consists of only ordinary shares each of which has a single face value. Sub-section (11) further provides that the said section shall also apply to insurers carrying on general insurance business.

Queries have been received from some insurers and intermediaries seeking clarification as to whether they can issue preference shares or certain other forms of hybrid instruments for augmentation of capital.

The Authority, after due examination, has decided that no insurance company shall issue any form of shares or hybrid instruments other than equity. The approach is consistent with the stipulation of the Authority at the time of registration of companies that additional requirements of capital would be funded through injection of equity capital at periodic intervals.

ii) Transfer of shares

As you are aware, sub-section (4) of Section 6A further provides that no insurer shall register transfer of its shares where, after the transfer, the total paid up holding of the transferee in the shares of the company is likely to exceed five percent of its paid-up capital or where the transferee is a banking or an investment company, is likely to exceed 2.5 percent of such paid-up capital, unless the previous approval of the Authority has been obtained for the transfer.

Since the intent of the legislation is that any change in the structure of shareholding pattern of an insurance company should have the explicit

approval of the Authority, it is clarified that such transfer shall also include renunciation of the rights by the existing shareholders. In other words, all transfers of shares in excess of the stipulated threshold and limits which result in change of either the pattern of the capital structure approved at the time of registration or the percentage approved by the Authority, would require prior approval of the Authority.

Insurers are advised that non-compliance with the requirement would be viewed seriously.

iii) Applicability to other intermediaries

The above stipulations are applicable mutatis mutandis to all intermediaries who have been granted registration as Third Party Administrators (TPAs) and Broking Companies.

In case any intermediary has issued capital in any form other than equity, or has raised funds through any hybrid instrument, immediate steps should be taken to redeem such instruments under a time bound programme, which has the prior approval of the Authority.

Sd/-

(C. R. Muralidharan)

Member

SUSPENSION REVOKED

The suspension of the licence of Direct Insurance Brokers M/s Vision Insurance Risk Analysis Management & Brokers Private Limited) has been revoked by IRDA. The order dated September 27, 2005 reads as follows: Re : REVOCATION OF SUSPENSION OF DIRECT INSURANCE BROKERS LICENCE (No 238/DB/03 of M/S Vision Insurance Risk Analysis Management & Brokers Private Limited)

The Authority had suspended the broking license of the above broker on 13th July 2005 for having failed to obtain a professional indemnity insurance policy. The broking has since obtained the PI policy from United India Insurance Company Limited for Rs 50, 00,000/- and submitted a copy of the same to the Authority vide their letter dated 15th July 2005. The broking company has further given an

undertaking vide their letter dated 5th September 2005 that it will promptly comply with the requirements stipulated under IRDA(Insurance Brokers)Regulations 2002 and also respond immediately to the communications received from the Authority. In view of the above, the Authority hereby revokes the suspension of the license NO 238/04 and permits the broking company M/S Vision Insurance Risk Analysis Management & Brokers Private Limited) to carry on its normal activities as a direct insurance broker with immediate effect.

Sd/-

(PC James)

Executive Director

IRDA Proposes Time Bound Detariffing

IRDA has come out with a time bound road map for the general insurance industry to go off the Tariff which binds various classes of business. The circular dated September 23, 2005 to heads of all Non-Life insurance company chief executives has a draft of the roadmap for discussion and reads as follows:

Road Map for a Tariff free regime

General insurance companies and other stake holders in the insurance market have been voicing the demand for removal of tariff as the existence of tariff was considered contrary to free market principles and insurance products need to be priced based on market forces. The Authority has accordingly considered moving to a tariff free regime in due course. A draft approach note is given below for the consideration of the insurers and the public.

MOVEMENT TO A TARIFF-FREE REGIME

In a market free of tariffs, any responsible insurer should have in place the following internal capabilities, procedures and controls. The Authority would like to highlight the various steps to be taken by the Insurers to ensure that the shift from a tariffed market to a market where the insurers are free to fix the rates and determine the terms and conditions of contract is as smooth as possible. While this note assumes that all lines of business would be detariffed, it is likely that, to start with, it may be limited to lines other than motor in view of the sizeable share the motor premium commands in the overall premium collected by Insurers and the large number of policyholders involved in this line of business. Whether the motor premium is detariffed or not it would be necessary to put in place sufficient safeguards to ensure that all vehicles get insurance cover at reasonable rates as motor tariff would be impacted in either scenario.

UNDERWRITING

The function of underwriting and rating of insurance business should be independent of the business development function and not be made

subservient to the business development function.

For operating convenience, every insurer will require to have an internal guide tariff for the smaller valued risks and the simple risks. Staff with authority to accept business will be trained to evaluate proposals and underwrite and rate risks as per the guide tariff. Risks not covered by the guide tariff must be referred to nominated underwriters stationed at higher offices of the insurer. These underwriters will be specially trained in evaluating risks, securing required inspection reports or risk evaluation reports and underwriting and rating of the risks and determining the terms and conditions of cover.

The insurer will have a risk inspection team within the organisation or may use the services of outside experts for risks evaluation.

The nominated underwriters with authority to accept or decline risks and to quote rates and terms will not report to any officer with business development responsibility but will only report to a senior level officer whose work and performance will be assessed on the basis of the results of the business underwritten.

There will be a core team of well qualified underwriters who will do an internal audit of the underwriting efficiency of the nominated underwriters. Where a nominated underwriter is found wanting in skills, he will be further trained. Where he is found to be careless or lacking diligence, his authority will be withdrawn.

The insurer will have a risk inspection team within the organisation or may use the services of outside experts for risks evaluation. These persons will be totally

independent of the business development staff and will only report to the head of the underwriting function.

All management reward schemes must be profit based.

RATING SUPPORT

The Appointed Actuary, in association with experienced senior underwriters of the insurer, will be responsible to list out the rating factors to be looked at for every sub class of business and every type of risk. He will also be responsible to draw up the internal guide tariff and for its periodic review.

Having identified the risk factors, the Appointed Actuary should ensure that all required data on the rating factors is captured in respect of every insurance underwritten by the insurer and in respect of every claim. He should work with the IT Department Staff to design the system for collection and compilation and analysis of data on premium and claims by the several risk factors. Such analysis should lead to a periodic review of the internal guide tariff and also serve as the technical input to nominated underwriters.

The Claims manger should be required to bring to the notice of the underwriting staff, any information of importance to underwriting of risks. Similarly, reports produced by the Loss Prevention Association of India should be studied by the underwriting staff and their underwriting policy should take note of any relevant information from such reports.

POLICY TERMS AND CONDITIONS

To begin with, all insurers will start with the policy terms and conditions as per existing tariffs. However, an insurer may review the terms and conditions and make changes therein for use after they are approved by IRDA. The IRDA will look at the changes from the point of view of the simplification of the language of the cover, underwriting prudence and technical soundness of the changes.

Risks which are rated on the basis of international market terms may continue to be governed by terms and conditions acceptable to the reinsurance markets of repute.

CORPORATE GOVERNANCE

Every report of the CEO to the Board of Directors on the business development must also comment on the emerging claims experience of the business and adequacy of the current underwriting and rating levels. Such reporting should be done at least once every half year.

Each insurer should have a Compliance Officer who will ensure that the system functions as it is expected to.

TARIFF ADVISORY COMMITTEE

With the abolition of tariffs, the role of the Tariff Advisory Committee will undergo a change. It can perform the following useful functions:

1. Collection of data on premiums and claims, analysis of such data and dissemination of the results to the insurers;
2. Report to IRDA on the underwriting health of the market and any aberrations in market behaviors;
3. Constitution of Expert Groups at the request of the General Insurance Council, to look into underwriting issues and recommend necessary action;
4. Organise training to underwriters at the market level; and
5. Attend to public grievances on non – availability of insurance and try to resolve the issues by discussion with insurers.

TIME SCHEDULE FOR IMPLEMENTATION

In order to prevent disruption of the smooth functioning of the market after removal of tariffs, all necessary actions should be taken in a time bound manner with target completion dates as follows:

Date of discontinuation of tariffs: 31st December, 2006

UNDERWRITING FUNCTION

1. Insurer to decide on the underwriting set up within its organisation: **01 Dec 05**
2. Insurer to decide on the classes of risks to be governed by internal tariffs and the classes that will be underwritten individually: **01 Dec 2005**.
3. Preparation of interim internal tariffs based on available underwriting information within the company: **31st March, 2006**.
4. Training of underwriting staff: **01st August, 2006**.
5. Training of nominated underwriters: **01st October, 2006**.
6. Set up the underwriting audit procedures, identify the auditors and train them: **01st November, 2006**.

In order to prevent disruption of the smooth functioning of the market after removal of tariffs, all necessary actions should be taken in a time bound manner.

7. Set up the risk inspection machinery and train the inspectors: **01st Aug, 2006**.

RATING SUPPORT

1. Identify the rating factors for every sub-class of business: **1st Dec, 2005**.
2. Modify the input screens of the company's IT system to capture information on all rating factors in respect of premium and claims: **31st Dec, 2005**.
3. Write and test the necessary programme for compilation and analysis of the captured data: **01st April 2006**.
4. Commence data capture and analysis from: **01st April 2006**.
5. Prepare first edition of guide tariffs based on analysis of compiled data,

to the extent possible, for every sub-class of business: **01st Nov, 2006**.

6. Prepare guidance notes on underwriting for nominated underwriters for risks that will be individually rated: **01st June 2006**.

POLICY TERMS & CONDITIONS

1. Review current tariff policy terms and conditions and recommend changes therein: **01st May 2006**.
2. Adopt new policy terms and conditions after approval by IRDA: from the date of detariffing to be announced.
3. Train underwriting and claims staff in the use of the new wordings: **31st Oct, 2006**.

CORPORATE GOVERNANCE

1. Prepare a detailed document of all activities related to the move over to a tariff free regime for submission to the Board: **01st December, 2005**.
2. Secure guidance and approval of the Board to the proposed activities: **01st Jan, 2006**.
3. Prepare the outline of the periodic report to the Board on the underwriting performance of the insurer: **01st April, 2006**.
4. Set up the system to compile information for the purpose of the report referred to in 3 above: **01st June 2006**.

All Insurers are hereby advised to implement the guidelines given above and comply with the milestones indicated. The Authority will monitor the response of the insurers to the guidelines in order to finally decide the date for moving to detariff regime. The Authority also welcomes feedback on the above in order to have a smooth transition from a tariff to a non-tariff regime.

Sd/-
(C.S. Rao)
Chairman

Where Education is Critical

– Informing the customer is key for the success of ULIPs

While ULIPs offer the best of both worlds – high returns and stable investment – policyholders must be made fully aware of its working, observes *D. V. S. Ramesh* while also spelling out how this can be achieved.

As the Chinese adage puts it so aptly, 'Gather ye rosebuds while ye may'. The life insurance needs of a person crop up as soon as one enters life itself. However, various factors convince individuals against opting for life insurance products.

The marketing of life insurance is always a matter of top priority at all levels. Over and above the recent concepts of globalisation, competition and innovation, the fundamentals of marketing concepts, such as keeping the policyholder well informed and making transparent disclosures, will never fade out.

In markets like India, people often consider insurance a waste, as one is over-sure of never requiring it. Against this backdrop, a savings element, which is made a part of the insurance premium in respect of endowment type of products, encourages people to view insurance products as savings together with protection.

As interest rates dwindle, insurers have to look towards shifting the investment risks on to the policyholders by adopting investment-linked products, from the traditionally guaranteed long-term policies with prefixed premium rates.

On the other hand, customers of insurers are also looking towards the market-linked returns on every bit of their investment. Unit-linked insurance products (ULIPs) allow customers to enjoy market-linked returns together with the option of having an insurance element based on their risk bearing capacity. It is the best option for the insurer to retain customers when interest rates look southward.

Need for education on ULIPs

By means of product design, the embedded characteristics of these

products are transparency, flexibility, segregation of charges with the saving element and market-linked returns with a hedge against inflation. However, in a budding insurance market like India where the life insurance industry has stuck with conventional products and where awareness of the capital market is abysmally low in the retail segment, the concept itself requires customer education before being introduced in the market.

Education in this context, as in any other, is a continuous process.

—

The marketing of life insurance is always a matter of top priority at all levels. Over and above the recent concepts of globalisation, competition and innovation, the fundamentals of marketing concepts, such as keeping the policyholder well informed and making transparent disclosures, will never fade out.

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Policyholders have a right to all information pertaining to the policies they propose to take. This may be analysed in two parts – presale education and postsale education.

Presale education

Since the product design is different from that of a conventional product where the sum assured may be based on the underlying fund value, the following are to be explicitly spelt out to the policyholder:

Functioning of the products

The manner in which these products work, how they are different from the traditional/conventional life products and how the returns under these products are linked to the performance of the underlying capital markets have to be explained. For instance, a friend of mine once sought a clarification – when a life insurance company launched a unit linked plan, whether it was coming out with a public issue at Rs. 10!

Sum Assured

As against traditional products, where a policyholder can see the sum assured and claim it as well, in ULIPs, the life assured cannot see the sum assured. It is quite often linked to the premiums paid or the underlying policy fund value. The statement of accounts received by the policyholders offer information on the number of units and its underlying policy fund value. In quite a few products, the sum assured even affects exercising certain options like partial withdrawals. This is the area where the prospect is expected to know what exactly the sum assured is under the policy and how this is subject to various factors.

Charges

In conventional life insurance products, the charges are embedded in the policy features and are not shown separately. In ULIPs, the charges are segregated and thus made known to the policyholder, so that overcharging cannot be hidden.

Other options

One of the characteristic features of these products is said to be flexibility. The following are some of the key points:

- ◆ Availability of various investment fund options that suit the risk appetite

- ◆ Flexibility of premium payment options
- ◆ Availability of liquidity features like partial/full withdrawals
- ◆ Room for additional premiums called top-ups
- ◆ Switching of investment funds from one fund to the others
- ◆ Premium redirection offers
- ◆ Status of policies due to non-payment of premiums, lapsing and its revival
- ◆ Maturity options
- ◆ Terminology and nomenclature of terms, charges and procedure regarding the appropriation of charges.

Post-sale education

Avoiding a possible mis-sale

Under the provisions of the IRDA (Protection of Policyholders' Interest) Regulations, 2002, policyholder are entitled to the refund of premiums if they feel that the policy offered is not according to their choice. This is to be done within 15 days. This particularly suits ULIP policyholders in India. One of the solutions to avoid a mis-sale is for the insurers to bring the factors influencing the ULIP specifically to the notice of the policyholders at the time of despatching the policy bond.

Re-design the policy bond

Providing the requisite information in a precise manner is one way of educating the policyholders. The policy bond is such a document that neither it entices the policyholders to read it nor can they understand the intricate terminology of these contracts. Re-design the policy bond in such a way as to draw the attention of the policyholders to the main factors, such as the funds offered, the terms of the contract and charges. Place all the charges and their appropriations in a tabular form at a single place.

Switching option

Switching amongst the available funds of the ULIP is one of its unique features. Unlike conventional policies, ULIPs allow policyholders to intervene at different points of time to transfer the funds either partially or fully from one fund account to the other.

In most ULIPs, the policy features generally offer more than one fund for the policyholder to choose from. This option is a special purpose tool that facilitates the policyholders in changing the investment portfolio based on their risk appetite and life stage.

It will be prudent for the insurance advisors to not advise their policyholders to switch without specifically explaining its implications. In some markets, the

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**By means of product design,
 the embedded characteristics
 of ULIPs are transparency,
 flexibility, segregation of
 charges with the saving
 element and market-linked
 returns with a hedge against
 inflation.**



regulators lay down certain guidelines for advisors. The policyholders are to be double cautious while exercising the switching option. The insurer should educate the policyholders on the pros and cons of this feature on a continuous basis.

Think long-term

As in all capital market-linked investments, the money in ULIPs needs sufficient time to grow. This is especially so in cases where higher upfront charges swallow a considerable share of the first few years' premium. The duration of investment horizon will have a significant effect on the final returns. With the investment fund options including a higher portion of investments in equity, policyholders

need to be informed about the requirements of longer durations to enable the funds to grow, accumulate and generate reasonable and higher rates of returns.

Benefits of rupee cost averaging

The regular premium plans of life insurance premiums enable investors to benefit from the advantages of rupee cost averaging. The contractual obligation of the policyholders to pay continuously in regular intervals effectively reduces the volatility risks related with capital markets. This factor, if the policyholders are aware of, will significantly nullify the option of the risk cover being allowed to continue even in case of non-payment of the premiums by appropriation of relevant mortality costs from the available policy funds. This awareness may reduce the policy lapse under these types of plans. This further will not lead to too many surrenders in the early years though policy provisions allow such options.

Working of equity returns

Policyholders should be aware that the returns under equity-linked investments outperform any other type of investments.

Investment does not translate into experience

Quite often, the investors may decide to invest in the stock market directly once they are exposed to such similar products. Let the policyholders be aware that investing in the stock markets directly needs dedication, study and analysis of the market and the possibility of their being carried away by market rumours. A less risky way will be to continue to rely on the professional fund management of the life insurers. The policyholders should be aware that by this means, the monies invested by them are diversified across various sectors of the markets. Thus, the risk is equally diversified.

Educating the stakeholders is part of business ethics. With innovative

conceptual products breaking into the markets and with the introduction of alternative channels in the life insurance sector, the customers now have a more mechanical approach where they may be missing a personal, thorough and extensive personal finance review by their life insurance advisors. Hence, the role of life insurers is paramount in educating the holders of these policies.

Policyholders invariably have a set of frequently asked questions (FAQs) on the available products and services. It may be appropriate for the life insurers to place the replies to these FAQs in various communications, advertisements and web portals (See list below.)

Educating the real stakeholders is one of the paramount duties of every agency, be it the government or the regulator. The agencies that are still striving to educate the public on various related matters are:

- ◆ The Investor Education and Protection Fund established by the Central Government in exercise of the powers conferred by clauses (a) and (b) of sub-section (1) of Section

642 of the Companies Act, 1956 read with sub-section (3) of section 205 C of the Act vide Investor Education and Protection Fund (Awareness and Protection of Investors) Rules, 2001.

- ◆ RBI educates the depositors on various matters like holding the deposits under 'either or survivor' mode, exercising the 'nominations'

It will be prudent for the insurance advisors to not advise their policyholders to switch without specifically explaining its implications. The insurer should educate



for hassle free settlement of deposits and creating awareness on 'Grievance redressal forums' available in the print media at periodic intervals.

- ◆ In order to protect investor interests in the securities market, SEBI has launched the Securities Market Awareness Campaign, under which SEBI has made available educative

materials in various regional languages in addition to other measures.

- ◆ As per Section 38 of PFRDA Ordinance, 2004, PFRDA shall establish a fund for educating and protecting the subscribers of the pension fund.

With the entry of private players and the consequential introduction of novel products, there is a need to educate the main stakeholders of the insurance industry as to the latent and intricate aspects of capital market-linked life insurance products. It is rare for the policyholders to have a close and clear study while choosing the products. Already, in shouldering the responsibilities of developing the nascent insurance industry, IRDA is spearheading a public awareness campaign at various fronts, both in the print and audio-visual media. It may be relevant to specifically focus on ULIPs at periodical intervals, inculcating greater awareness in the public.

The author is Assistant Director, IRDA. The views expressed here are his own.

FAQs

- | | | |
|--|--|---|
| 1. What is a life insurance policy? | 14. Are the charges constant or variable? If variable, how do I know? | 25. May I pay more than what I have to pay under this contract? |
| 2. Is it unit linked life insurance policy? | 15. What if I disagree if it varies towards a higher side? | 26. What is NAV? How it is calculated? |
| 3. What is ULIP? | 16. Am I fit for opting for this ULIP? | 27. What is Unit? |
| 4. How shall I pay the premiums? | 17. Is it the appropriate time to enter the ULIP? | 28. Who will manage my monies? How do I know where my monies are? |
| 5. How does it differ from the traditional products? | 18. How do the switches help me? | 29. How do I know the available units and their value in my policy account? |
| 6. Are there ULIPs with interest/bonus guarantees? | 19. Can I alter the ULIP product to other conventional products based on my life requirements? | 30. Who will advice me on switches? How shall I know the timing of the switch? |
| 7. Is the risk coverage extended? To what amount? | 20. Do the ULIPs have any exclusions? | 31. Who will be supervising your company? |
| 8. Does it vary with time or is it constant? Is this sum assured guaranteed? | 21. Who will redress my grievances? | 32. What are the disclosures? |
| 9. Is it covered with any charge? | 22. Can I revive the ULIP after a lapse? | 33. Are any guarantees offered? |
| 10. Does it vary based on age or is it constant throughout the term? | 23. Can I surrender the policy like any other life insurance policy? How will my liquid requirements be met under these types of policies? | 34. Why shall I not invest directly in stock markets? |
| 11. Will the amount be managed free of cost? | 24. Can I have a rider attached to the policy? If so, will the premium be inclusive or exclusive of this? | 35. Shall I have an illustration? How did the company determine the rates in this illustration? |
| 12. What are all the charges? | | |
| 13. How to remit my charges? How do I know about my charges? | | |

Report Card:LIFE

27% Growth up to August

First Year Premium Underwritten by Life Insurers for the Period Ended August, 2005

Sl No.	Particulars	Premium			No. of Policies / Schemes			No. of lives covered under Group Schemes								
		Aug.05	Upto Aug.05	Upto Aug.04	Aug.05	Upto Aug.05	Upto Aug.04	Aug.05	Upto Aug.05	Upto Aug.04	Aug.05	Upto Aug.05	Upto Aug.04	Market Share		
1	Baraj Allianz	15,650.44	42,916.44	14,395.73	198.12	4.75	46,576	1,48,290	70,237	111.13	1.68	10,697	71,329	52,208	36.62	2.13
	Individual Single Premium	6,820.57	15,694.37	5,035.22			7,477	18,777	5,657							
	Individual Non-Single Premium	8,612.74	26,261.02	9,259.88			39,052	1,29,407	64,549							
	Group Single Premium															
2	ING Vysya	2,17.12	961.04	100.63	88.40	0.54	47	106	31			10,697	71,329	52,208	77.64	0.31
	Individual Single Premium	1,420.17	4,910.19	2,606.27			9,382	29,167	34,928	-16.49	0.33	2,255	10,477	5,898		0.31
	Individual Non-Single Premium	1,269.49	4,390.06	2,432.79			9,376	28,789	4,781			263	1,026	255		
	Group Single Premium	101.66	375.62	121.14					30,141			1,992	9,451	5,643		
3	AMP Sanmar	49.02	142.14	19.83	126.49	0.46	6	29	5			7,098	37,311	21,305	75.13	1.12
	Individual Single Premium	1,250.02	4,129.54	1,823.25			5,865	20,896	12,321	69.60	0.24	2,098	37,311	21,305		1.12
	Individual Non-Single Premium	914.87	2,703.05	848.12			1,403	4,403	1,785			263	1,026	255		
	Group Single Premium	294.00	1,121.51	851.89			4,453	16,452	10,507			7,098	37,311	21,305		
4	SBI Life	26.50	244.29	92.70	3.50	1.46	9	41	28			7,098	37,311	21,115	5.96	8.39
	Individual Single Premium	3,648.87	13,215.63	12,768.21			16,532	59,310	34,128	73.79	0.67	1,04,703	2,80,671	2,64,883		8.39
	Individual Non-Single Premium	373.30	1,595.41	2,641.90			636	2,415	1,483							
	Group Single Premium	1,086.92	3,901.24	1,994.24			15,721	56,273	31,641			10,373	87,422	64,713		
5	Tata AIG	544.12	1,289.46	2,288.78	64.49	1.66	175	620	1,001			94,330	1,93,249	2,00,170		8.59
	Individual Single Premium	3,604.73	15,051.07	9,150.07			27,760	1,10,337	79,673	38.49	1.25	37,660	2,87,217	1,29,927	121.06	8.59
	Individual Non-Single Premium	73.26	180.85				27,734	1,10,205	79,565			13,964	60,482	38,025		
	Group Single Premium	3,198.38	13,302.77	7,168.45			26	132	108			23,696	2,26,735	91,902		
6	HDFC Standard	7,078.61	26,985.06	9,671.52	179.02	2.98	28,324	1,02,626	59,213	73.32	1.16	6,246	51,111	57,363	-10.90	1.53
	Individual Single Premium	844.96	4,057.83	2,848.85			7,667	22,895	6,222							

7	Individual Non-Single Premium Group Single Premium Group Non-Single Premium ICICI Prudential Individual Single Premium Individual Non-Single Premium Group Single Premium Group Non-Single Premium	5,712.40 449.39 71.86 16,029.98 589.27 14,563.53 82.08 795.10	19,801.77 1,768.89 1,356.57 62,465.48 2,343.53 52,778.41 171.02 7,172.52	6,385.36 272.09 165.22 39,977.55 6,536.80 29,626.01 14.96 3,799.78	56.25	6.91	20,646 9 2 59,773 6,147 53,613 8 5	79,670 47 14 2,16,581 7,494 2,08,989 46 52	52,924 61 6 1,81,635 4,115 1,77,471 6 43	19.24	2.45	6,170 76 25,205 1,26,314 96,273 30,041 19,844 5,361	43,005 8,106 31,965 295.16 1,101 30,864 19,335 -65.99	3.78		
8	Birla Sunlife Individual Single Premium Individual Non-Single Premium Group Single Premium Group Non-Single Premium	4,324.09 103.85 4,106.42 63.60 50.22	15,545.47 435.47 14,334.82 217.03 558.16	18,150.60 541.85 13,864.37 177.19 3,567.18	-14.35	1.72	19,803 3,312 16,489 2 320	65,870 17,607 48,246 17 973	48,022 9,612 38,378 32 180	37.17	0.74	599 6,575 1,993 4,582 17,961 74,908 499 100	6,575 1,446 17,889 49,047 1,446 17,889 49,047 52.73	2.24		
9	Aviva Individual Single Premium Individual Non-Single Premium Group Single Premium Group Non-Single Premium	2,510.26 82.61 2,402.31 11.19	9,740.00 145.21 9,423.96 57.58	5,623.20 148.79 5,372.65 6.38	73.21	1.08	9,140 320 8,819 1 14	36,079 973 35,102 4 25,078	29,521 180 29,326 1 14	22.21	0.41	17,961 74,908 61 369 17,900 74,539 4,919 27,626	74,908 35,009 34,869 -34.95 3,088 24,538 3,505 22,681	0.83		
10	Kotak Mahindra Old Mutual Individual Single Premium Individual Non-Single Premium Group Single Premium Group Non-Single Premium	1,867.08 293.84 1,515.93 22.88	6,383.09 587.44 5,502.93 46.17	3,626.48 707.27 2,313.86 605.35	76.01	0.71	7,250 299 6,941 1 9	25,078 894 24,163 1 20	16,225 470 15,740 105 65,505	54.56	0.28	4,919 27,626 1,597 3,088 3,322 24,538 3,505 22,681	-21.09 35,009 34,869 -34.95 3,088 24,538 3,505 22,681	0.68		
11	Max New York Individual Single Premium Individual Non-Single Premium Group Single Premium Group Non-Single Premium	2,876.70 6.91 2,868.16 0.00	11,540.48 63.60 11,418.88 58.00	6,356.25 108.08 6,185.48 62.69	81.56	1.28	37,332 11 37,318 3	1,23,775 84 1,23,662 29	65,505 105 65,364 36	88.96	1.40	3,505 22,681 3,505 22,681 3,505 22,681 3,505 22,681	-34.95 35,009 34,869 -34.95 3,088 24,538 3,505 22,681	2.85		
12	Met Life Individual Single Premium Individual Non-Single Premium Group Single Premium Group Non-Single Premium	887.76 47.97 762.21 0.00	3,325.61 197.62 2,899.61 228.38	1,522.84 51.62 1,147.84 323.38	118.38	0.37	7,296 96 7,175 25	27,867 379 27,405 83	10,489 123 10,327 39	165.68	0.32	37,315 95,307 37,315 95,307 37,315 95,307 37,315 95,307	12.79 84,501 84,501 200 200 200 200 200	0.01		
13	Sahara Life Individual Single Premium Individual Non-Single Premium Group Single Premium Group Non-Single Premium	68.44 18.95 49.49 0.00	262.63 18.95 243.48 0.20	5,844.71.09 98,999.59 3,52,287.64 1,33,183.86	72.25	0.03	1,952 56 1,896 3	10,803 56 10,744 3	9,76,679 78,67,756 6,98,616 71,63,478 5,662	6,41,897 70,23,186 2,38,853 67,79,425 4,908	52.16	11.04	2,58,163 7,37,721 7,37,721 22,52,648 22,52,648	38.84 17,99,441 25.19 7,86,310 17,99,441 32.64 67.36		
14	LIC Individual Single Premium Individual Non-Single Premium Group Single Premium Group Non-Single Premium	1,90,987.63 7,822.09 83,950.46 2,8816.08	6,87,959.71 2,43,809.21 3,36,058.49 1,08,092.01	5,844,711.09 98,999.59 3,52,287.64 1,33,183.86	17.71	23.93	2,76,985 2,10,011 21,65,865 1,587	9,76,679 78,67,756 6,98,616 71,63,478 5,662	6,41,897 70,23,186 2,38,853 67,79,425 4,908	52.16	88.96	2,58,163 7,37,721 7,37,721 22,52,648 22,52,648	38.84 17,99,441 25.19 7,86,310 17,99,441 32.64 67.36			
	Grand Total	2,52,204.77	9,04,430.39	7,10,143.06	27.36	100.00	2,65,444.8	88,44,435	76,65,083	15.39	100.00	9,95,884	33,44,375	25,85,751	29.34	100.00

Note: Cumulative premium upto the month is net of cancellations which may occur during the free look period.

The Insurance Kingpin

– How underwriters uphold the interests of all stakeholders

Underwriting means a whole range of job functions, analytical capabilities and roles that generate good decisions for the organisation, observes *P. C. James*.

Underwriting is a quintessential insurance skill, and can be termed an insurer's core competence. In a world that is increasingly governed by uncertainties and vulnerabilities, the underwriting capabilities of the individual and the organisation need to be forward looking, dynamic and innovative. Everyone, therefore, agrees that underwriting has to move from being a *rule-based task* to a *risk-based skill*.

In a tariff-based underwriting regime, the pristine underwriting skills tend to atrophy and this would be an important reason to move on from rigid tariffs to flexible, value-based underwriting.

The skills of underwriting are compatible with all the known characteristics of the industry. Thus, insurance is commonly perceived as sold and not bought, and therefore the push factor predominates, especially in new business procurement.

Typically, an insurer will look with wariness at a new prospect voluntarily and energetically trying to buy a cover direct from an insurer. It is well known that such pull factor is clearly manifested at a time that insurers would term as 'apprehensive period'.

The traditional values of intermediation and the push factor can be invaluable to a good underwriter, including the personal knowledge of the risk by the intermediary, reduction of moral hazard due to the insurance being sold, a more authentic filling of the proposal form guided by a trained intermediary, and the availability of the intermediary to clarify grey areas, inspect the risk if required and so on.

Therefore, if the apparent dissonance and discordance perceived between underwriting and marketing can be

converted into a powerful synergy, the spread of insurance can be catapulted to higher levels of growth than seen today in general insurance.

Underwriting as a marketing tool

Sound underwriting is also good marketing. Marketing is ultimately about attracting the customer by creating and offering value to him.

Underwriting typically endeavours to fashion offered risks into better – and therefore insurable – risks, and to

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Good underwriting can free the mind of an entrepreneur or organisation to focus on its competence in the area of business risks and transfer non-business risks to the insurer.

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transfer the risks so as to recoup unforeseen losses. It assists the insured to grasp the potential threats contained in a risk, minimise hazards and improve safety features so as to reduce downtime and costs.

Therefore, a good underwriter turns out to be one who is close to the customer and a top marketer for the insurer by attracting clients through capability in unravelling and understanding risks and ensuring betterment in a transparent and intelligible manner.

Ideal underwriting tends not only to improve the insurability of the risk and reduce its risk features, but also endeavours to modify and improve the risk inducing behaviour of the insured. Good underwriting can thus free the mind of an entrepreneur or organisation

to focus on its competence in the area of business risks and transfer non-business risks to the insurer.

An experienced underwriter will slowly begin to 'own' customers merely by being true to competencies in underwriting.

A consumer friendly activity

Underwriting is often pictured as an activity that merely betters the bottom line of the insurer and therefore acts against the insured. Nothing can be further from the truth.

Good underwriting in its essence offers true protection, and helps the insured in all aspects of risk management. It helps to determine the level of self-insurance, the implementation of loss minimising steps, the amount of risk transfer, and the levels of sum insured, the deductibles, warranties and conditions that are acceptable and so on.

Thus, good underwriting can attract enormous customer goodwill. This builds for the insurer a high level of sustainability and reputation.

Good underwriting opens up and educates customers on the many aspects of understanding risk protection and assists them in all areas of risk improvement. This has manifold spin-offs which are likely to increase, as one can visualise a future where managing an increasing risk milieu will be the key to survival and sustainability.

Ongoing progress and development will throw up more and more risks for individuals and organisations, and hitherto unseen vulnerabilities will get more starkly exposed.

Underwriters, thus, will increasingly be valued as specialists in

risk recognition, risk assessment, risk management, risk transfer, risk acceptance and risk retention and prove a boon to a society that looks to a future which will be secured through the mastery of risk.

Good underwriting thus becomes a tool for social good, as well. It differentiates between good risks and bad risks and advises risk betterment, enforces warranties, seeks compliance of laws, regulations and various safety practices, and finally prices risk in such a manner that risk improvement is made an underlying necessity for day-to-day activities. An underwriter's nod that insurance can be granted often acts as a good certificate to bankers, auditors, other stakeholders and the public. Thus, good underwriting needs all encouragement, as this alone will bring in awareness of risks and endear the public to insurance buying.

Deepening and widening insurance protection in all sectors of the economy is considered essential for development and social engineering. This results in risk contraction in the lives of people and organisations and supports progress and prosperity.

Good underwriting, and its underlying prudence, enhance safety and security and raise the confidence level of all the stakeholders in the society.

A challenging task

From an insurer's point of view, underwriting is important because of the complexity involved in taming risks. Risks can be small or big, concentrated or dispersed, simple or complex, static or dynamic, frequent and/or severe, have short- or long-term effects. Its full dimensions are hard to fathom and keep changing as knowledge and development move forward.

Clients have diverse needs and may seek a varied menu of covers. There is a constant need for innovation in the area of products and coverage features. The underwriter is expected to display great expertise in the containment of risks, distinguish between insurable

risks, risks that are insurable with improvements, uninsurable risks and non-insurable risks.

The delineation of risks from the green insurable to the red uninsurable and its articulation to the insureds to satisfy their needs and wants, and at the same time generate the necessary upside to the business opportunities of the insureds by securing the future through risk containment, while protecting the bottom line of the insurer, makes the work of an underwriter both challenging and forbidding.

In this scenario, insurers must face the fact that insurance underwriting can be hard work. The yield, however, is considerable, and not only translates into a better bottom line for both parties,

Good underwriting is a tool for social good, as well. It differentiates between good risks and bad risks and prices risk to encourage risk improvement.



but also generates excellent business and social dividend in the long term. In order to achieve this, an insurer needs to integrate insurance capabilities into the prevailing economic landscape, the local geographical contexts, the relevant social milieu and so on.

Underwriting by its very nature needs to be proactive and developmental. If a country is to move into a higher developmental orbit, it can do so only on the back of mastery over risk. Risk, other than business risk, is the complex area in which businesses and individuals look to insurers and other such organisations for mitigation, transfer and relief.

To protect the insured, the underwriter needs not only to look at past experience and data but also on the ever-changing environments in which

new risks and hazards incubate. Perspectives on risk analysis now not only compel number crunching and data analysis but also look into the hard-to-make-out area of the behavioural and other human dimensions.

The easy route to underwriting can be statistical, but there is considerable value in adding to it intuitive, qualitative and futuristic elements. Looking into the history of accidents alone can be misleading, the instances of near misses due to system deficiencies are even more important. The list of risk fields needs to scan not merely tangible physical risks, but even more importantly intangibles such as contracts, obligations, agreements and commitments.

The essence of the art

The essence of underwriting is risk recognition, assessment, shaping, containing and pricing. It includes the ability to measure the dimensions of potential loss exposure as well as to set and obtain an adequate return for accepting the risk transfer. The underwriting process thus has many aspects:

1. Information capture and management

Data, information, knowledge and experience are the lifeblood of good underwriting practices. Underwriting is moving away from anecdotal and unverified experiential conclusions to one led by a mass of clear data collected over time and geographies, and models and structures which can be created to sustain clear underwriting strategies.

2. Hazard recognition and evaluation

Insurers are grappling with new strains of risks and catastrophes while fighting off softening premium rates. Global warming and environmental degradation threaten to unleash greater and more frequent catastrophes, terrorism and social tensions tend to escalate risks on the human side, technology and progress in life sciences create anxieties in areas of unknown losses and so on.

More mundanely, every ordinary underwriter needs to grapple with the many consequences of the risks that are placed before him/her, and consider its various dimensions to contain those risks and price them to create value for both the customer and the insurer. There can be considerable differentials based on location, technological, social and moral factors.

3. Selection

Grading of risks plays a role that is important in terms of equity for the customer and survival for the insurer. Grading can be on various parameters such as frequency/severity, desirable/undesirable, long term/short term, concentrated/dispersed, etc. Risk betterment, pricing, warranties and conditions, limitations on the cover offered indicate the choices before the insurer while considering a risk. It is also possible that a risk is not insurable and the reasons need to be spelt out.

Every risk thus will be graded and considered on a scale of excellent to uninsurable to enable the underwriter to go to the next step of pricing.

4. Pricing

Pricing is the most important factor of underwriting, as markets are dynamic and customers are dictated by the costs they face in transferring risks. Underwriters would often face the paradox that they are required to offer more and more benefits at softening rates and terms. Deficiency in pricing, at the same time, is fraught with severe consequences.

However, underwriters have many weapons in their armoury which can include well known techniques, such as application of deductibles, imposition of warranties, limiting of covers, deletion of perils and ceiling on claims, to ensure that prices and risks accepted match in a way that the insurer gets a return on the capital deployed.

The real issue of pricing is to ensure that there is full pricing, which includes the various costs such as commission,

management costs, provision for catastrophic losses and an expected profit margin, on top of the burning cost or basic net price. Good underwriters are also good practitioners in ensuring reduction in claims and dispute costs through clear and transparent terms of contract.

5. Application of coverage

Coverage criteria depend on a mixture of physical and moral hazards seen. Good underwriting also assists in the fit or alignment of risks affecting the insured to the coverage offered, so that there is clear value for the insured. Coverage also looks into areas such as the limits of cover, the deductibles imposed, terms, conditions and exclusions, and whether these are

The delineation of risks from the green insurable to the red uninsurable and its articulation to the insureds, while protecting the bottom line of the insurer, makes the work of an underwriter both challenging and forbidding.

aligned with the coverage intent of the insured and the premium charged.

6. Feedback and control

Management of sound underwriting will always seek to understand and evaluate the results and strive for betterment based on feedback. Control systems and procedures will be embedded in the organisation to ensure that the orthodoxy required is maintained. The feedback loop will be kept alive and enhanced as a channel for continuous improvement and innovation. Good underwriting will be open to learning and innovation.

The challenges to good underwriting are many. For an insurer, this includes

capacity constraints, regulatory compliances, reinsurance arrangements and, most important, the quality of personnel, especially their attitude to underwriting professionalism, the richness of their experience and knowledge and the ethical values they hold. An organisation will also have to articulate clearly the economics of underwriting, so as to enable underwriters to meet the operational challenges in meeting the returns on invested capital.

The shape of underwriting tasks for underwriters in a matured market is probably different from those of a developing market. In the Indian context, the readiness of insurers and employees to move to risk-based underwriting needs to be examined and skills sharpened due to the onset of the detariffed regime and a huge market that waits for growth on the back of well managed underwriting and selling.

The new underwriter

The new underwriter will be focused on the dynamics of risk and will not be trapped by the rigidities of outdated procedures and rules. Such an underwriter will adapt to global best practices, be updated on facts and analyses, avidly build up hands on experience and keep expanding in the knowledge areas concerned.

In order to move into a new orbit of excellence, the underwriter will not get confused with legacy issues but will look at risks with new understanding. For instance, the traditional 'fire' insurance, while insuring assets on a wide variety of material damage covers, will need to look at all the factors affecting these covers including all relevant locational, physical and social risks, apart from those concerned with fire alone, which traditionally one would be habituated to.

Similarly, an Overseas Mediclaim Policy is not health insurance, but is a travel insurance where the risks are different. A good underwriter needs also to ponder at what point of time a travel insurance policy gets changed into

foreign residence insurance, and what are the risk differentials arising from a long stay abroad.

In a similar vein, in the case of a health insurance policy, it will be proper to examine at what age an annual policy generally could become effectively a long-term care policy. In general, underwriters need to look for answers on complex and evolving issues such as the infusion of technology, the phenomenon of outsourcing, the question of obsolescence, the many challenges in determining an acceptable sum insured, the question of the right type of sum insured, how to factor in inflation, currency fluctuation, etc. There are also emerging areas such as contractual, professional and legal risks, as also processes and services risks where customers seek answers to their protection requirements.

Pricing challenges in a soft market is going to set apart the men from the boys. Pricing discipline requires excellence in examining the boundaries of various possibilities on the one side to satisfy customer expectations dictated by market conditions, and at the same time re-examine the orthodoxies of underwriting to arrive at terms that will still get a return on equity as desired. It also means having the courage to vacate segments that are hopelessly under priced till pricing conditions return to normal.

The underwriting-focused insurer

Good underwriting displays mature corporate capabilities, helps capacity building, and generates customer value. It also enhances shareholder and industry value. Underwriting entails strict discipline and requires structured decision making, uniformity and consistency in approach. It needs to translate individual experience and skills into corporate insights and learning. More importantly, underwriting is for profit and will focus on return on capital. Rigid adherence to sound underwriting practices helps to ensure staying power through pricing cycles and ensures a long corporate life.

Converting underwriting into a core competency can offer value to the organisation in various ways:

1. It helps to naturally home in on profitable areas of business and generates true profitability and return on capital.
2. It serves the customer by unlocking value in risk areas, and seeks to help to channel customer energy to other productive areas.
3. It reduces costs to the insurer in after-sales service and helps to reduce claims ratio and interpretational complications.
4. It is a great platform for customer understanding and dialogue, thereby helping to reduce the potential for

The new underwriter will be focused on the dynamics of risk will not be trapped by the rigidities of outdated procedures and rules, adapt to global best practices, be updated on facts and analyses, avidly build up hands on experience and keep expanding in the knowledge areas concerned



grievances and disputes.

5. It generates sustainable market goodwill and brand equity.

The challenge for the organisation is to build and sustain an underwriting and R&D culture, to establish and live by a clear set of principles, and to focus relentlessly on execution in the face of contrary market practices.

The temptation to fall for short-term growth oriented strategy or what is called cash-flow underwriting, at the cost of undermining the underwriting foundations of the organisation, can lead

to an inexorable decline in both reputation and profits.

Underwriting excellence needs to advance continuously to enhance customer benefits. The insured perceive the deficiencies in the offerings made and the unnecessary costs loaded on to them. Therefore, good underwriting needs to consider the following:

1. Alignment of risk classes as perceived by customers to the actual insurance coverage offered.
2. Assisting the insured to review insuring limits by looking at adequacy in line with PML, catastrophic loss potential and other relevant factors.
3. Keeping the terms, conditions and exclusions aligned with the coverage intent decided upon or advised to the insured.
4. To bridge the gap between coverages available and offered.
5. To endeavour to fill the gaps in cover seen between policies.

The new underwriting will need to look at coverage enhancements and improving the breadth of coverage by well-researched methods by recognising new risks coverage requirements and reconfiguring existing coverage. Insurers will keep monitoring the cost efficiency of coverage in terms of various consumer costs in terms of money, time cost, energy costs, psychic costs and so on.

The insured public is increasingly perturbed that the ratio between recoverable loss through insurance and actual loss is often 1:4, partly owing to disruptional and reputational damages, but also partly and regrettably due to gaps in coverage or inadequacy of limits offered for coverage.

Insurers need to work on restructuring their conventional insurance offerings in order to attract organisations to move on to higher order coverage which will enable them move from mere regulatory, or banker/auditor induced insurance buying to genuine risk

and protection management.

This higher order protection requirement will become a corporate necessity as organisations wish to move on to areas of operational loss/cost reduction, seek enhancement of ratings from independent rating agencies and ultimately as they seek to achieve market leadership.

An insurer's survival and sustainability are rooted in the ability to contain risks and price adequately risks accepted. Underwriting means a whole range of job functions, analytical capabilities and roles that generate good decisions for the organisation. Therefore, an underwriting culture needs to pervade the organisation so that adequate primacy is given to underwriting priorities across various functions over other urgencies.

A good underwriter will eventually emerge as the leader because of the futility and ineffectiveness over the long term of techniques and solutions that rely on wishful thinking, guesswork and

accommodations.

The underwriter will then become a rightful decision maker because he/she carries out the primary task of risk acceptance and revenue generation for the organisation that makes a difference between its success and failure.

Therefore, the nurturing of a good underwriting philosophy, a culture of research and data analysis along with supportiveness of innovation and futuristic orientation will differentiate good companies from the others in the future.

The challenge for the organisation is to build and sustain an underwriting and R&D culture, to establish and live by a clear set of principles, and to focus relentlessly on execution in the face of contrary market practices.

The author is Executive Director (Non-Life), IRDA. The views expressed here are his own.



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Underwriting in a Detariffed Environment

– The need for ‘hard’ and ‘soft’ skills

The Tariff system should encourage the development of underwriting skills at operating levels at the insurance companies as well as reinsurers, says *A. S. Chaubal*.

Determining the adequacy of premium rates it charges is perhaps the biggest dilemma faced by the insurance industry the world over. ‘Soft’ and ‘hard’ market conditions globally characterise the underwriting cycles within the insurance industry. Introducing ‘tariff’ controls and ‘detariffing’ are the obvious consequences of these cycles, their timings being driven by local market conditions.

Major classes of non-life insurance in India, including the profit making Fire and Engineering classes, have been subjected to tariffs for the past many decades. These tariffs have effectively played their roles in the nationalised set-up, though with limited objectives. With the process of liberalisation and opening-up of the market to private players, introduction of intermediaries etc., the insurance industry has moved forward at a rapid pace, changing the perceptions of the players as well as insured.

Recognising the fact that the tariff regime should end as early as possible to allow a free play to market forces as an essential part of a liberalised market, IRDA appointed the Expert Committee headed by Mr. A. C. Mukherji. The committee was mandated to examine the remuneration system for insurance brokers, agents etc. It made specific recommendations in December 2003 to make a changeover in a phased manner from a tariff regime to a “Pure Risk Rate Regime” and then to a fully detariffed open market.

Though a variety of views were expressed on the recommendations of the Expert Committee, there is a unanimity of view among the majority in favour of ‘detariffing’ all classes including Motor, Fire and Engineering. The market thoughts are now focused

on answers to questions like:

- ◆ What is a “pure risk”?
- ◆ What is the so called pure risk rate?
- ◆ How can it be determined, especially in the absence of any reliable statistics?
- ◆ What would be the other factors (acquisition cost, administrative costs, reserves for future catastrophic loss etc.) that an insurer

Fire and Engineering are two major and important classes of Non-Life property insurances, where risks have substantially high single loss exposures and the single loss estimates may far exceed the gross direct premium written by individual insurance companies.

loads the ‘pure risk rate’ with, before quoting to a customer?

- ◆ Is rate the only element to be considered or it could be the rates, terms and conditions for different combinations of coverages?
- ◆ Will TAC do it or it be left to each insurer to draw his own tables of rates and deductibles?
- ◆ How can it be implemented at the market level?

- ◆ Whom should it apply to? Across the board to all customers or a selected group of customers?.
- ◆ What would be the monitoring and control strategy/mechanism?
- ◆ What would be the effects of such a change over to ‘pure risk rate regime’ in terms of the industry income and balance sheets of individual players?
- ◆ What is the life expectancy of the Pure Risk Rate Regime?
- ◆ How would it affect the reinsurance arrangements and relationships?
- ◆ What could be the set-up to build up reliable statistical data on a market level?
- ◆ How to ensure healthy market growth in the liberalised pricing set-up?

The first attempt at the level of the Tariff Advisory Committee (TAC) is aimed at detariffing the Motor class of business. An internal committee of experts is looking into various aspects of Motor detariffing. This exercise is actively underway and it is learnt that specific ideas may emerge in a not too distant future to effect the changes in a phased manner.

Fire and Engineering are the other two major and important classes of non-life property insurances, where a large number of technicalities and complexities will come into play in deciding what can be the Pure Risk Rate. It would be pertinent to note that both these classes write risks of substantially high single loss exposures and it may not be unlikely that the single loss estimates far exceed the gross direct premium written by individual insurance companies in their

respective departments. Discussions in the subsequent paragraphs will, therefore, be focused on these two major classes of non-life insurance business.

Before dwelling upon the aspects that surround the approach to determine a technically sound or correct rate (in the present market situation perhaps a 'realistic rate'), it would be pertinent to look into what the Insurance Act 1938 states.

Section 64 UC of Insurance Act

"In fixing, amending or modifying any rates, advantages, terms or conditions relating to any risk, the Advisory Committee shall try to ensure that there is no unfair discrimination between risks of essentially the same hazard, and consideration is given to past and prospective loss experience.

"Provided that the Advisory Committee may make suitable allowances for the degree of credibility to be assigned to the past experience, including allowances for random fluctuations and make suitable allowances for future fluctuations and unforeseen future contingencies including hazards of conflagration or catastrophe or both."

Let us now look at the historical developments of Fire and Engineering insurance tariffs and associated regulations in India, the current situation and likely solutions towards rate-making on technically based parameters.

Fire

Prior to introduction of the All India Fire Tariff with effect from December 31, 1978, four Regional Fire Tariffs were in use in the TAC regions of Mumbai, Kolkata, Delhi and Chennai. These tariffs were administered, monitored and controlled by the respective Regional Committees, who were supported in their tasks by various Sub Committees and Technical Groups who dwelt upon finer aspects of specific topics.

TAC dealt directly only with the insurers and not with any of the insured

clients. The tariffs and regulations were 'Confidential for the use of Insurers alone.' Each of the Regional Committees had its own team of qualified engineers to carry out risk inspections purely from the angle of compliance with TAC regulations relating to fire prevention / protection systems, electrical installations, building regulations, etc. There existed a specific system of "Special Rating" wherein, with the help of a variety of check lists (specially drawn to quantify physical features of general and industry specific nature), the basic tariff rates were modified to effectively have a 'merit based' rate for a specific large value account.

Thus, as would be expected of any regulations, the system by and large catered to a large number of small

The Tariff books ran into hundreds of pages and were difficult to handle physically and in course of time the demands increased to make the books smaller in size and weight for better mobility. The concept somehow found popularity and acceptance at some levels and this was perhaps the starting point of the erosion of the technical base of the Tariffs.

clients in a generalised way and equally gave special treatment to large ones by considering the specific physical risk features implemented by the clients. The whole system responded very well to the recognition of individual industry risk features to arrive at modified tariff rates. Review and revision was a continuous process through deliberations at the Fire Sub Committee (which met weekly) and other higher level committees.

Each of these Regional Tariffs was in technically elaborate detail and fully took into account the Fire rate, making "hardware" elements of occupancy, construction, location, fire prevention/ protection systems, etc. It did not respond to the subjective "software" issues of management systems such as work permits, no-smoking rules, staffing (quality & training), emergency response and control systems.

Rates and terms for natural perils were separately prescribed along with corresponding endorsement wordings and, wherever possible, technical basis available from reliable researches were adopted. For example, the Earthquake Zoning of India for the purpose of Fire Tariff closely follows the relevant Indian Standard published by the Bureau of Indian Standards.

Towards rationalisation

The first major exercise of rationalising these Regional Tariffs was undertaken by TAC in 1977 to remove regional disparities among comparable risks. As a result, the All India Fire Tariff, uniformly applicable to the country as a whole, came into effect on December 31, 1978. This tariff continued to adopt the same sound technical base that formed the Regional Tariffs. The system of 'Special Rating' also continued undisturbed. The rationalisation process resulted in the reduction of about 25 per cent of the Gross Direct Market Fire premium. Cases of hardship were individually looked into for viable solutions.

The Petrochemical Tariff of TAC, which caters to petroleum refineries, petrochemical plants and fertiliser plants, does have a sound technical base in as much as it utilises the Dow Chemicals Manual for hazard quantification. Nevertheless, in spite of the sound technical base, the whole system was never well received by the insured clients for a variety of factors – major ones among them being confidentiality of documents and delays.

TAC also had the responsibility of collection of statistical returns from the

companies. Though the statistical data was never received at 100 per cent level, what used to be received by TAC was representative enough for decision making. The data collection was based on 'occupancy' codes. In the absence of computers, the entire processing of data was done manually.

With the consistently favourable claims experience of the Fire Tariff based portfolio, support of international players in the reinsurance programme of the industry (i.e. GIC and the then four subsidiaries together) could be readily available over many years. Nevertheless, the industry had to respond to international insurance and reinsurance market situations on critical issues like Terrorism insurance and TAC came out with a set of rates and terms for the Indian market.

Small Risks that are very large in number, administratively uneconomical to carry any special exercise of rate making on an individual basis. Perhaps, a small band of risks from the Medium Size may be shifted to this group by changing the definition to a little higher value of say about Rs. 10 to 20 crore. This will ensure a stable premium base for the whole portfolio. Statistics for this group must be available with the insurers and GIC today.

The Medium Size risk group may be taken for judging the first impact of Fire detariffing, with an indirect rating control of GIC and/or other international reinsurers. How do we decide the level of adequate rates for individual risks within the group?

Can it be by straight, reducing the Tariff rates by some percentage to take care of the administrative and acquisition costs of the insurers supplemented by introducing a 'Bonus Malus' formula to touch the experience base which may be available with respective insurers even within the present market situation?


Or, can it be by falling back to the concepts of the old All India Fire Tariffs or the Regional Tariffs? Needless to

mention, the system should have simplicity of working and hence adopting the old system as it was may not be advisable.

The third alternative would be to leave it free and open to the insurers to decide what they consider as appropriate rates and terms. Though this may sound drastic, the fallout of the chaotic 'price driven aggressive marketing' may be restricted to about one third of the overall portfolio premium and can also lead to the expansion of the premium base.

An elaborate system of filing returns of statistics with TAC can be introduced with common software programmes to be prescribed for use by all insurers.

The insurance needs of clients have changed drastically over the past decade, especially with a large number of infrastructure projects with private funding on 'non-recourse' basis requiring a different type and level of insurance response.



Finer issues of monitoring and control mechanisms for administering any of these alternatives would require detailed deliberations at appropriate quarters.

Engineering

The Engineering class of insurance encompasses a larger variety of products as compared to Fire and also is a mix of Long Term Project Insurance policies (such as Marine Cum Erection Insurance, Erection All Risks, Contractors All Risks, Contract Works Insurance and Advance Loss of Profits Insurance) as well as Annual Operational Insurance policies (such as Machinery Breakdown, Boiler Explosion, Electronic Equipments

Insurance, Contractor's Plant & Machinery Insurance, Civil Engineering Completed Risks Insurance, Deterioration of Stocks Insurance plus Machinery Loss of Profits Insurance).

The first attempts at the TAC level to prepare Tariffs for all classes of Property Damage Insurances in the Engineering departments started in 1977. Tariffs prepared by the Technical Assistance Group (Engineering) for practically all classes came within about five years, primarily with the objective of achieving market level uniformity of approach in rating small value risks (Rs. five crore). Being small in number, all individual policies of larger values in all classes were specially rated by the Technical Assistance Group (Engineering).

At no stage was it intended that high exposure, long term business of large values be left for the generalised tariffs for smaller risks. This enabled the industry to exercise effective control on both the Tariff and Reinsurance driven risks. The limit of Rs. five crore gradually got extended up to Rs. 100 crore. Large, high value risks still remained within the controlled domain until the limit for tariff applicability to projects got enhanced to Rs. 1,500 crore. This has eroded the underwriting control on such high exposure risks substantially.

Let us now look at the rating factors for two major classes of Engineering, viz. EAR/CAR and Machinery Breakdown Insurances:

EAR / CAR - rate factors

- Nature and type of contract / works
- Period – overall & testing commissioning + maintenance
- Method of construction
- Storage arrangements and periods
- Location – soil/geology/meteorology, seismology and other
- Design – proven or prototype
- Contractor's experience

Extensions – TPL, surrounding property, removal of debris, custom duty

Deductibles

Machinery breakdown rate factors

- ◆ M - Machine itself, type/use,
- ◆ I - Incidence of loss / breakdown,
- ◆ C - Construction (simple/ complicated)
- ◆ A - Availability : repairs/ maintenance/spares,
- ◆ S - Site conditions,
- ◆ H - Human element,
- ◆ Le - Loss experience

The insurance needs of clients have changed drastically over the past decade, especially with a large number of infrastructure projects with private funding on 'non-recourse' basis requiring a different type and level of insurance response. The tariffs today may not be capable of meeting such needs of the insurers in preparing insurance programmes to fully respond to the project specific insurance needs.

The corrective measure that may be effective would be to restrict the Tariffs

only to small value policies of, say Rs. 50 to 100 crore, and leave the balance to be reinsurance driven. The long-term survival of this portfolio will depend on the reinsurance markets including GIC.

The Tariff system cannot respond to each and every situation in a generalised

A viable approach to detariffing would be to not make any change for the small risks that are very large in number where it is administratively uneconomical to carry any special exercise of rate making on an individual basis.



way and may prove useful for smaller risks which form a larger base for individual portfolios.

The system should encourage the development of underwriting skills at

operating levels at the insurance companies as well as GIC. The professional services of brokers need to be more effectively utilised and outsourcing of specialised services should be welcome. Keeping pace with developments the world over and within the Indian economy, and the need for flexibility of insurers to draw insurance programmes to the specific needs of clients, assume predominance.

Though the interim phase of a changeover from a controlled pricing mechanism to a free market is essential for stability in the market place, it would be necessary to take all players into confidence to discuss the long-term and short-term effects of such measures. The whole exercise has to finally lead to market growth on healthy lines, developing skills and a sound database for the industry.

The author is Managing Director, BMS India Intermediaries Pvt. Ltd. The views expressed here are his own.

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Broker as Bridge

— How a broker can be a key link in the underwriting process

Brokers know the pulse of the customers, and therefore can help underwriters with their actual data as well as risk management skills, writes *V. Ramakrishna*.

Have you ever taken a roller coaster-ride in an amusement park? It takes frightful twists and turns, runs upside down and in the dark. You can barely perceive where the next hill, drop, or twist will take you. As a joy ride this can be fun and exhilarating...but as a company trying to survive in the underwriting market, it can be rather nerve-wracking.

A major challenge being faced by insurance carriers across the country is that they are under pressure to ignore sound underwriting principles. The market has become highly volatile, competitive and risky. The bid for the top slot has deteriorated into a fight for survival.

The industry, as a whole, has been through lot of turmoil in India. We have seen the pre-nationalisation days, followed by a long period of nationalisation and now, the present stage, where the market has been opened up to private players. We have state owned players co-existing with private companies. Added to this is the presence of brokers and Third Party Administrators (TPAs). The insurer seems to be facing a dilemma when trying to look forward along with sticking to its basics. It is in a precarious situation, wherein it needs to grow in volumes, make profit, provide quality service and manage expenses.

What will then be the ideal role of a broker in assisting the industry in getting *back to the basics*? Answering this question first calls for a discussion of the main strategies and approaches to ensure consistently profitable results through the underwriting cycle.

What are good underwriting practices?

'Good underwriting practices' indicates the practices to be adopted by an underwriter in consistently collecting all the material facts that lead to understanding the risk in its totality,

advising risk minimisation measures and charging the optimum rate applicable to the perils to be covered.

In the case of tariff business, it also implies adherence to the tariff.

The risk underwriting process can be broadly classified into five distinct phases:

Identify and evaluate

This primarily depends upon gathering the proper information to assess the risk and correctly identify the types of risks, exposures and controls that are in the account.

Organisational risk is no longer simply hazard risk but also operational, financial and strategic. Brokers can help clients determine their exposures and structure their insurance programmes.



Make underwriting decisions

This phase focuses on making two distinct underwriting decisions. Based on the industry, the insurance company's risk appetite and the risk exposures as identified and evaluated in the first phase, the underwriter reaches a decision on whether or not to pursue the risk. The second decision the underwriter takes is the assessment of the overall quality of the risk compared to the peers within its group.

Decide terms and conditions

In this phase, the underwriter uses information collected thus far to establish the terms and conditions for the policy. By considering the quality of the risk, the terms can be set to give the insured adequate coverage while properly

protecting the insurance company.

Decide price and premium

Based on the exposures, the quality and the terms, the price and premium can be set by the underwriter.

Negotiate

This is the final phase of the underwriting process. This can be an area where even the best-priced risks are compromised. Even more experienced underwriters will, in the heat of pursuing the risk and under pressure for growth, abandon their underwriting discipline.

Knowledge

Underwriting is about knowledge. In order to be effective, underwriters need to have a wide array of knowledge readily available to them.

Where we are today

The market reality today is that underwriting practices have been long forgotten. As per Darwin's theory, in the game of survival, only the fittest survive. This may prove right in the years to come. But in today's chaos of number games, the focus is on the one that grabs the maximum business. This leads to the following conclusions:

- ◆ There is no logic behind the drop in premium rating
- ◆ Tariffs are being violated
- ◆ Wrong advice is being given to the client
- ◆ Unhealthy market practices have become rampant
- ◆ Loss history is being tampered with

A broker to the rescue

If utilised correctly, knowledge and information furnished by a broker can enable consistency in the underwriting process in the following ways:

Risk management

A broker can organise risk management programmes. In many industries where safety standards have been declining due to the costs associated with their

implementation and support, risk management will play a vital role. Risk management controls protect the organisation, its operations, its reputation and its people. Organisational risk is no longer simply hazard risk but also operational, financial and strategic. Brokers can help clients determine their exposures and structure their insurance programmes.

Conveying the true picture

Since, in the near future, the broker would practically become the “client” of the insurer, he would need to convey the actual risk status and refrain from giving a skewed picture to the insurer which might jeopardize the rating pattern.

Comprehensive underwriting submissions

While a filled proposal form is the minimum requirement, a good broker should reach beyond that and make a comprehensive submission – with as much additional information on company, product, industry, manufacturing process and promoters as possible. Company and product brochures, web site printouts, plant photographs, promoter profiles, etc aid the underwriting process.

Knowledge

A broker can contribute more effectively by collecting all the relevant information that will lead to the underwriter being able to give an appropriate and fair rate. This will require the broker to understand the client’s requirement in totality. He needs to do an in-depth study including the business process of the client, industry trends and benchmark rating for a similar risk.

Research and analysis

Brokers can provide market research and analysis that will help the insurer make pricing decisions based on sound information rather than market pressure. In this market, pricing discipline is crucial.

Prepare for de-tariffing

Brokers should build adequate in-house technical expertise in the form of people and knowledge - both for current and future requirements. Once the

market is de-tariffed, brokers will be on test to ensure proper risk-rating is done with the help of data and knowledge. It is important to store data and ensure a feedback cycle as time goes by so that insurers can use the same for better rating.

Efficiency

Good underwriting takes time. Brokers can help generate time for the underwriters to carry out their tasks well. Activity-based cost studies at several carriers have shown that underwriters spend less than half of their time on core value added underwriting tasks. Non-core tasks can be performed by brokers.

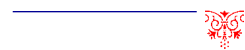
Technology

Technology will play an even larger role in servicing. By providing a client

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A broker can contribute more effectively by collecting all the relevant information that will lead to the underwriter being able to give an appropriate and fair rate. This will require the broker to understand the client’s requirement in totality.

— — — — —



with a web-based facility, a broker can save considerable time for the insurer as well as the client. New integrated technologies combine traditional risk management, work management and knowledge management capabilities into cohesive underwriting support tools. Technology can ensure a consistent approach to underwriting and deliver knowledge and information to the underwriter based on the type of risk and the phase of the underwriting process.

Innovation

Insurers need to innovate constantly and bring out new products in anticipation of customer needs and market trends. Brokers, who are in

constant touch with clients, are best equipped to capture such trends and needs and help insurers design new products.

Long-term perspective

Brokers should keep in mind that, in the long run, they cannot grow at the collective expense of the underwriters. Only a healthy underwriting discipline can ensure long-term survival of underwriters and, consequently, that of brokers.

Minimisation of moral hazard

While sophisticated models have been developed to evaluate physical risks, there is no better tool than human judgement to identify and avoid moral hazard. Brokers, as the eyes and ears of underwriters, should have the courage to avoid clients with obvious moral hazard. This will not only protect the insurer’s balance sheet, but also enhance the broker’s reputation, both with clients and insurers.

After all, while there can be thousands of clients to chase, there can only be a handful of insurers to support a broker with quotes.

Discipline and planning

These are required to effectively and efficiently manage the insurance roller coaster. The high performing companies will apply discipline in the underwriting process with the help of brokers to ensure that best practices are followed during each of the underwriting phases so that premiums are not lost and losses are avoided. Discipline is also required in knowledge management to ensure that information and knowledge are delivered in the most valuable way to best improve performance.

With brokers training their focus on these areas, insurers can ensure more predictable underwriting behaviours, which will yield more predictable underwriting results. This, in turn, will help the carriers gain greater control over the peaks and valleys of the roller coaster ride.

The author is Managing Director, India Insure Risk Management Services (P) Ltd. The views expressed in this article are his own.

Gauging a Pool

-A practitioner's view of the basics of group insurance underwriting

How is a group of employees examined for the risks it presents to the insurer? What are the tools to be used and precautions to be taken? *Dr. Rajeshree Parekh*, a practicing underwriter, has answers to these queries.

An underwriter is the individual responsible for assuming financial liability associated with a particular risk. He or she determines the terms and conditions under which that risk is acceptable. In most cases, the underwriter wants to ensure that, on average, profit is achieved.

Insurance companies are sometimes referred to as underwriters. However, underwriting is only one of the functions managed by an insurance company and its employees. Insurers help their clients by assuming risk in return for a premium. They create a pool of risks, to spread the impact of any individual claim over a larger group. Losses from any one risk are offset by profits from others.

An underwriter protects that pool of risks from risks of a lower quality. He or she evaluates insurance applications to determine the degree of risk represented, rejects some risks and, in some cases, raises premiums. The underwriter attempts to protect the overall performance of the pool by ensuring that risks going into the pool do not threaten the financial performance of the pool. Where underwriting is not carried out carefully, the insurer loses money.

Rating the community

When an individual applies for an insurance policy, the underwriter's role is well chalked out – examine the buyer's background thoroughly before gauging the risk. However, group employee benefits insurance, which provides cover to employees of a company or an organisation, also requires underwriting. Group policies can provide coverage to as few as 50 employees, or to huge companies in the private or public sector. Common employee benefit coverages include death benefits, disability benefits and medical benefits.

Group underwriting is generally less concerned with the insurability aspects of a particular individual – except in the case of an outlier. The aim is to obtain an aggregation of a group of risks that will yield a predictable rate of mortality and morbidity, allowing pricing. The very nature of employee benefits insurance acts as a form of underwriting. Covered employees are typically individuals who are sufficiently healthy to retain full time employment.

The underwriter attempts to protect the overall performance of the pool by ensuring that risks going into the pool do not threaten the financial performance of the pool. Where underwriting is not carried out carefully, the insurer loses money.



However, the underwriter should note that providing insurance to a small group of employees is significantly different from the case where the group is large. The following table lists the key differences:

Small Insured Group	Large Insured Group
More vulnerable to individual claim, therefore more risk averse.	Less vulnerable to individual claim, therefore less risk averse.
Less flexibility in plan offerings and coverage levels.	More flexibility in multiple plan offerings and coverage levels.
Less flexibility in funding options	More flexibility in funding options
Less or no experience rating, pricing is more dependent on the claims history of the entire pool.	Generally experience rated, pricing is more dependent on the claims history of the entire pool.
Age banded rate structures are often used to determine premiums.	A unit rate is used to determine premiums for all employees in the group.

Groups can be fully insured, self-experienced or self-insured. With a self-experienced group, the employee bears some financial volatility. A loading is built into premiums and used to pay an annual bonus. The annual bonus is not paid if the group has bad experience. A self-insured group is not insured and bears the full risk of any claims, paying claims out of its own funds.

In other markets, small groups will be fully insured and mid-sized policies self-experienced. Large groups often self-insure their group health plans, with or without purchasing stop-loss protection. In the Indian environment, most employer groups find it beneficial to be fully insured since most insurance plans make little or no underwriting profit.

Varied approaches

Underwriters make use of qualitative and quantitative approaches to make underwriting decisions. Individual underwriters make decisions within a framework set by the insurance company and may have limits on their individual authority. In many organisations, risks beyond a certain size cannot be accepted without reinsurance.

The underwriter in an insurance firm works within in a matrix. Some of its characteristics are:

Diversification must be managed

For a group insurance pool to perform adequately, enough normal risks must be written to support losses from substandard groups not rejected by the underwriting process. The underwriter should not accept risk beyond a reasonable capacity – an inadequately priced large group can damage the pool as a whole.

Data is used

Underwriting relies on information provided by the insured group. Always check the reasonableness of the information provided.

Equity must be maintained between insured parties

Each insured group should be treated in an equitable manner. Accepting bad risks without loadings will cause financial loss to the insurer as a whole and may result in premiums being raised for both bad and good risks.

Compliance with local legislation -
Underwriting must comply with local insurance legislation.

Assumptions have to be made -

Underlying assumptions have to be made about risks. Life insurance underwriting — quite obviously — relies on mortality assumptions. While health insurance underwriting relies on morbidity assumptions, that of disability insurance makes use of incidence rates for disability.

Within this matrix, an underwriter is expected to perform a careful analysis of the risk using qualitative techniques. Key factors that may indicate a problem with the risk include demographics characteristics, the industry in which the employees operate, the financial outlook, workforce stability, work site locations, carrier persistency and levels of employee or dependent participation in the plan. In this area, the following forms a good checklist that can assist the underwriter in risk assessment:

Insurance must be incidental to the group:

The group must have been established for some purpose other than to obtain insurance. If not, the group would have the same experience as any retail insurance policy.

Group size:

The size of the group has a significant impact on the predictability of the group's average cost and risk factors. In addition, a group's size impacts the sensitivity to anti-selection and the likelihood of inclusion of substandard risk. In most markets, an automatic cover limit will vary with the size of the group. Individual sum assureds below that limit would not be underwritten.

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Flow of persons through a group:

It is important to determine whether the group is open or closed. If the group is closed, population characteristics (average age, dependent content, average income) will change over time.

Group stability:

The stability of a group is a sign that experience for that risk may vary from past experience. Group instability should be looked for in several areas. Financial instability and insolvency can

lead to layoffs and bankruptcy. Frequent plan design changes will also affect the relevance of past experience.

Anti-selection and participation:

Benefits can be non-contributory. Benefits would be offered to all eligible members of the group at no cost to the member. In some cases, benefits are contributory, that is, members pay a contribution to receive coverage. Some contributory benefits are also voluntary, wherein the eligible member can choose not to take coverage. Contributory and voluntary benefits may have significant anti-selection issues associated with them.

Minimum participation by the group:

Another underwriting control against anti-selection is the requirement that a substantial majority of all eligible individuals in a given group be covered by insurance. In non-contributory plans, 100 percent of individuals participate. In contributory plans, there is typically a 75 percent requirement. In voluntary plans, this can vary from 25 to 40 percent. When only a small proportion of the workforce is covered, the covered persons can often represent an undue proportion of substandard lives.

Demographic content:

Age is the single best indicator of future mortality and morbidity. Sex can also be a major factor, as many medical conditions are sex-related.

Geography:

There are significant regional differences in medical practices and prices. Healthcare costs and utilisation are affected by practices in a local geography and the care options available in an area. These differences would impact claims from medical coverage.

Quantitative Tools

While the above are qualitative tools, the underwriter also needs to utilise quantitative tools while assessing a group for insurance cover. Some of these are:

Loss ratio analysis:

Loss ratio analysis is widely used in underwriting. Its purpose is to gain an understanding of claims, which in turn allows the insurer to form a forward-looking estimate of incurred claims and load those claims to arrive at a premium.

Premiums are normally determined as:

Premium = Expected Incurred Claims* + Margin+ Expenses / profit / risk / taxes

**Expected incurred claims include expected paid cash claims and anticipated changes in incurred, but not reported, reserves and other reserves.*

The underwriter should be aware that past data is not necessarily reflective of future experience. The term 'credibility' is used to describe the relevance of historical data in projecting future costs. The number of employees covered in each year of data, and the number of years of data that is available, determines the credibility of the data. Generally speaking, the more data you have, the greater the credibility of historical experience.

Where a group is not credible, it is often pooled with other such risks. Loss ratio analysis is performed on the pool as a whole to guide pricing and derive rates for manual pricing. Loss ratio analysis is also used in pricing, where data is credible for an individual group.

The most commonly used rating techniques are:

Experience rating

Where a group has credible experience, loss ratio analysis is performed on that group's experience and used to guide pricing.

Manual rating

This is the process of using a set of rates based on the experience of the entire pool. Premiums would be calculated using those rates. A group adjustment of some kind (Group Age Sex Factor / Plan Age Sex Factor, Group Utilisation Rate / Plans Utilisation Rate Factor) would be incorporated.

Other group adjustments for geographic location and changes to plan design can also be incorporated.

Blended rating

This is the process of using client specific experience and manual rating to project future claims. Premiums would be calculated based on a weighted average of the manual rated premium and the premium based on experience rating. The weighting assigned to each will vary with the credibility of the group's historical experience.

Quality of data critical

Data gathering is one of the most important aspects of any underwriting process. It is often overlooked or not well

Data gathering is one of the most important aspects of any underwriting process. It is often overlooked or not well thought-out. Timely and accurate information is very critical to the entire underwriting practice.



thought-out. Timely and accurate information is very critical to the entire underwriting practice. Understand the intended use of the analysis being performed and its impact. Get it right the first time to avoid burdening the prospect with multiple requests. Be clear and specific.

Typical data elements for group underwriting include:

Group census data

Eligibility, date of birth, gender, dependent tier, plan geographic location, salary, date of hire, date of termination and date of retirement.

Rate information

Current rate and previous rate history, use of self-funding or insurance,

employee contribution rate, rates by products and by tiers. Third Party Administration fees and Individual Stop Loss/Aggregate Stop Loss charges

Claims data

Frequency and utilisation data, monthly paid claims, billed claim charges, allowable claims, large claims, paid and incurred claim lag triangle, plan designs and cost-sharing features, detailed benefit schedule, changes in benefits, provider discount level and fee schedule for in-network vs. out-of-network claims.

Armed with sound principles and an effective set of analytical tools, an underwriter can perform a diligent and efficient assessment of risk for group insurance. The biggest challenge to an underwriter, however, is not the science of underwriting, but having the ability to set emotions aside in the face of an opportunity. Take a step back, and ask yourself if a risk is worth taking.

The author, a qualified ophthalmologist, heads the Employee Benefits operations of Marsh India Pvt. Ltd. The views expressed here are her own.



प्रकाशक का संदेश

पिछले कुछ वर्षों में क्षेत्र में निजी क्षेत्र की प्रतिस्पर्धा आरम्भ हुई है और उद्योग का प्रभावशाली विकास उन निजी और सार्वजनिक क्षेत्र की कम्पनियों के योगदान के कारण हुआ है, जो बाज़ार का विस्तार करने में सफल हुई हैं।

प्रशुल्क ने अधिकाँशतया प्रतिस्पर्धात्मक शक्तियों के प्रतिकूल प्रभावों से कम्पनियों की रक्षा की है। पिछले दशकों से इसने प्रति-राजसहायताओं की प्रणाली का सृजन किया है और अब इसे हटाने की जरूरत है ताकि उद्योग को प्रतिस्पर्धात्मक बाज़ार स्थान में वाणिज्यिक सफलता प्राप्त करने के लिए उपयुक्त अवसर प्रदान किया जा सके। इससे एक ऐसे उद्योग का मार्ग प्रशस्त होगा जो उपभोक्ताओं की जरूरतों को उचित मूल्य पर पूरा करेगा और स्वयं के लिए सतत लाभप्रदता पा सकेगा।

बीमे के प्रतिस्पर्धात्मक और उपयुक्त मूल्य निर्धारण के लिए एक मूलभूत आंतरिक आवश्यकता हामीदारी का तकनीकी कौशल है। **IRDA** जर्नल के इस अंक में इस बात की चर्चा की गई है। हमारे संदर्भ में, उद्योग को वास्तविक रूप से हामीदारी पर लौटना है क्योंकि यह कुछ दशकों से प्रशुल्कों पर निर्भर रहा है और इसने वैयक्तिक जोखिमों का मूल्यांकन करने और इनका सही रूप से मूल्य निर्धारण करने के कौशल काफी हद तक खो दिए हैं।

प्रशासित मूल्य से मुक्त मूल्य निर्धारण की ओर बढ़ रहे किसी बाज़ार की सबसे महत्वपूर्ण बाहरी आवश्यकता विनियामक द्वारा एक अच्छा क्रम निर्धारण और निगरानी है ताकि बाज़ार अधिक से अधिक स्थिर रहे और

उथल-पुथल होने के बावजूद भी अंत्य उपभोक्ताओं की रक्षा की जा सके। प्राधिकरण कार्यक्रम तैयार करके इसके लिए कार्य करता रहा है, जहाँ विभिन्न कार्यों के लिए विभिन्न महत्वपूर्ण बिन्दु निर्धारित किए जाते हैं ताकि प्राधिकरण प्रशासित मूल्य निर्धारण से जोखिम मूल्य निर्धारण की ओर संक्रमण की निगरानी कर सके।

सितम्बर के आरम्भिक दिनों में हमें नए सदस्य (गैर-जीवन), श्री के. के. श्रीनिवासन का प्राधिकरण में स्वागत करने का अवसर मिला जिनके पास उद्योग के तकनीकी और कानूनी मामलों और हाल में प्रशुल्क परामर्शी समिति (TAC) से संबंधित मामलों का अत्याधिक अनुभव है। वे दिन-प्रतिदिन आधार पर प्रशुल्क मुक्ति प्रक्रिया में हमारा मार्गदर्शन करेंगे। हम जर्नल के इस अंक के माध्यम से भी उनका हार्दिक स्वागत करते हैं।

जर्नल के अगले अंक में देश में उपलब्ध कुछ ऐसी सामाजिक सुरक्षा योजनाओं का ब्योरा दिया जाएगा जो बीमा प्रकृति की हैं। इससे हमें उस सुरक्षा तंत्र की प्रकृति और कार्यक्षेत्र का ज्ञान मिलेगा जिसकी देश को हमारे लोगों के लिए वित्तीय स्थायित्व और सुरक्षा के लिए तलाश है।

श्री. एस. राव

सी. एस. राव

“ कुछ तो लोग कहेंगे ”

चाहे हम संयुक्त उद्यम का गठन करने के लिए तैयार हों, फिर भी कानून हमें इसकी अनुमति नहीं देता क्योंकि लॉयड्स एक बाज़ार है। हम यह आशा करते हैं कि भारतीय सरकार लॉयड्स की संरचना को पहचाने और अंततः हमें बीमा क्षेत्र में प्रवेश करने की अनुमति दे....

हम प्रत्यक्ष बीमा और पुनर्बीमा – दोनों में रुचि रखते हैं।

लॉर्ड पीटर लेवीन, अध्यक्ष,
लॉयड्स ऑफ लंडन

हामीदारी और बीमा व्यवसाय को दर्ज़ा देने का कार्य व्यावसायिक विकास कार्य से मुक्त होना चाहिए और इसे व्यावसायिक विकास कार्य का सहायक नहीं बनाना चाहिए।

श्री सी. एस. राव, अध्यक्ष, IRDA भारत में गैर-जीवन बीमा में प्रशुल्क मुक्त व्यवस्था के लिए कार्यक्रम की रूपरेखा बताते हुए।

मौसम वैज्ञानिक अनुसंधान में यह अनुमान लगाया गया है कि सभी आर्थिक कार्यों का 80 प्रतिशत कारोबार और लाभप्रदता मौसम पर निर्भर है।

नवाचार और बीमा संबंधी रुझानों के संबंध में
म्युनिख रे रिपोर्ट

आप संभवतया जोखिम समाप्त नहीं कर सकते, (पर) सम्पूर्ण उद्योग इसकी घटनाओं को कम करने के लिए बहुत अधिक परिश्रम कर रहा है। आप हमेशा उस दिन बिल्कुल शुद्ध सूचना प्राप्त नहीं कर सकते, जिस दिन आप इकाई मूल्य निर्धारित करने जा रहे हैं।

श्री स्टीव सोमोगयी, सदस्य, आस्ट्रेलियन प्रुडेन्शियल विनियमन प्राधिकरण (APRA) गलत मूल्य निर्धारण की घटनाओं के बारे में, जिनका योग मुख्य रूप से इकाईयों के मूल्य के संबंध में हाल के व 11 में 240 मिलियन आस्ट्रेलियन डॉलर से अधिक रहा है।

हम फर्मों से इस सिद्धांत का पालन करने की अपेक्षा करते हैं कि उन्हें अपने ग्राहकों पर उचित ध्यान देना चाहिए और उनके साथ निष्पक्ष व्यवहार करना चाहिए। अधिकांश फर्मों का ऐसा करने का उद्देश्य है – आखिरकार अपने ग्राहकों के साथ निष्पक्षता का व्यवहार न करना वाणिज्यिक रूप से उपयुक्त नहीं होगा – पर हम अभी भी ऐसे उदाहरण देखते हैं, जहाँ ऐसा नहीं होता।

श्री क्लाइव ब्रिऑल्ट, प्रबंध निदेशक,
खुदरा बाज़ार, वित्तीय
सेवाएँ प्राधिकरण
(FSA), UK

पूँजी की लागत बीमाकर्ताओं की लाभप्रदता परिभाषित करने में एक महत्वपूर्ण भूमिका निभाती है और हामीदारी की लाभप्रदता लाभप्रद उच्च विकास और प्रचालनों के पैमाने के साथ निवेशक के विश्वास की एक महत्वपूर्ण चालक है।

स्विस रे की नवीनतम सिग्मा रिपोर्ट।

एक स्वागतयोग्य कार्यभार

श्री मेथ्यू वर्धीस, सदस्य (गैर-जीवन), IRDA 22 महीनों की सेवा के बाद 31 अगस्त को सेवानिवृत्त हुए।

श्री वर्धीस ने अपनी कार्यावधि पर संतोष के साथ देखते हुए कहा कि उन्होंने यह जानते हुए यह काम संभाला कि एक नया उद्योग और एक नया विनियामक कार्य करने के लिए एक रोचक और चुनौतीपूर्ण प्रस्ताव होगा। वे कहते हैं कि यहाँ और विदेश में उद्योग में 36 वर्ष तक काम करने के बाद यह एक स्वागत योग्य कार्य था। हैदराबाद स्थित कार्यस्थल में गोल्फ खेलने के लिए बेहतरीन वातावरण था और इसलिए यह बहुत अच्छा लगता था!

वे कहते हैं कि यह कार्य बहुत व्यस्तता वाला था पर ग्राहकों और ट्रेड यूनियनों की ओर से काम का कोई दबाव नहीं था। वे हँसते हुए यह कहते हैं कि इस प्रकार समिति की बैठकें और रिपोर्टें ऐसी नई चीजें थी, जिनके वे अभ्यस्त हो गए हैं।

जो पहली बात वे प्राधिकरण में अपने काम के बारे में याद करना चाहेंगे, वह है – स्वास्थ्य बीमे के लिए तृतीय पक्षकार प्रशासक (स्वास्थ्य सेवाएँ) ;ज्द्व प्रणाली को सरल बनाना। वे आरम्भिक दिन थे और वहाँ शुरुआती समस्याएँ थीं। “ग्राहक यह अनुभव करते थे कि उनसे ज्द्व सेवाओं के लिए अधिक पैसा वसूला जा रहा है

और कम्पनियाँ यह महसूस करती थीं कि IRDA नें उन्हें इन नए सेवा प्रदानकर्ताओं का उपयोग करने के लिए विवश कर दिया है। प्रणाली की शुरुआत करने वाला IRDA इसके महत्त्व से प्रभावित था पर उसने यह अनुभव किया कि इसके लिए बेहतर जाँचों और संतुलनों की आवश्यकता है।”

श्री वर्धीस में ऐसे परिदृश्य में पणधारकों को एक दूसरे से बात करने के लिए प्रेरित किया और धीरे-धीरे मामले का समाधान कर दिया। अब लगभग 70 प्रतिशत समस्याओं का समाधान हो गया है और प्रणाली विभिन्न रूपों में लाभ प्रदान कर रही है, जिसमें यह तथ्य सम्मिलित है कि अब 85 प्रतिशत दावा आँकड़े ज्द्व प्रणाली के माध्यम से प्राप्त किए जा रहे हैं जो केवल बेहतर हामीदारी और दावा प्रबंधन में योगदान कर सकता है।

स्वास्थ्य बीमा बाज़ार और उत्पाद के विकास के संबंध में की गई पहलें

भी कुछ ऐसी बातें हैं, जिन पर वह वापस संतोष के साथ देखते हैं। स्वास्थ्य बीमा संबंधी कार्यदल ने नए उत्पाद विकास – जैसे पहले से मौजूद रोगों के लिए बीमा सुरक्षा – और उन स्वतंत्र स्वास्थ्य बीमा



कम्पनियों के लिए सूचना संग्रह और मानकों का विकास करने के संबंध में कार्य किया, जिनके लिए उन्हें आर्थिक रूप से व्यवहार्य बनाने और उनके प्रवेश को प्रोत्साहित करने के उपाय के रूप में माँग निम्नतर प्रवेश पूँजीगत मानकों के लिए थी।

वे कहते हैं कि दलाली के वातावरण में परिवर्तन चरणबद्ध रूप से जारी रहेंगे। उस बाजार को अब व्यापक बना दिया गया है जिसका दलाल उपयोग कर सकते हैं और प्राप्त करने के लिए अब उनके पास नए क्षेत्र हैं। वे स्पष्ट करते हैं कि पाँच प्रतिशत विशेष छूट विशेष कारणों की वजह से रखी गई है। इनमें से एक कारण यह है कि कोई परिवर्तन सभी पणधारकों के लिए समान होना चाहिए और किसी ऐसे लाभ को नहीं हटाया जा सकता, जिसे कोई पक्षकार कई दशकों से प्राप्त करता रहा है। इसका एक अन्य कारण यह है कि छूट की सुविधा को रखने से उन मामलों को दृढ़ता से स्थापित करने में सहायता मिलेगी जहाँ दलाल मूल्य योजित करते हुए देखे जाते हैं – अर्थात् यदि कोई बीमित पक्षकार दलाल की सेवाओं का उपयोग करता है और इसलिए छूट छोड़ देता है, तो इससे दलाल के परामर्श का मूल्य स्थापित होता है।

श्री वर्धीस कहते हैं, “हम यह चाहते थे कि ऐसा बाजार की शक्तियों के माध्यम से हो, न कि आदेश द्वारा।” पर वे प्रधान बीमा परिषद में उसके लिए अभीष्ट स्व-नियामक की भूमिका हाथ में लेने की प्रगति में कमी से नाखुश हैं। उसे शीघ्र ही यह भूमिका अपनानी है क्योंकि उसे मानक निर्धारित करने के लिए कार्य करने हैं, और कई मुद्दों पर कार्रवाई करनी

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प्रशुल्क मुक्ति कैसे की जाए और उद्योग के सर्वोत्तम हितों को कैसे बनाए रखा जाए, गैर जीवन बीमा उद्योग के संबंध में विनियामक की एक मुख्य आसन्न चिंता है।

है, जिनमें अन्य पणधारक संगठनों के साथ बाजार व्यवहार सम्मिलित है। “चरणों में” प्रशुल्क मुक्त करने के लिए भी मंत्र है। वे कहते हैं, “यह कई वर्षों से एक मिश्रित बाजार रहा है और अचानक परिवर्तन करने के लिए उदारीकरण के बाद ये आरम्भिक दिन हैं। प्राधिकरणों के गतिशील होने पर प्राधिकरण एक ऐसे बाजार में एक ही बार में प्रशुल्क हटाने की बजाए बाजार को स्थिर करना चाहेगा,

जो हम सोचते हैं कि विभिन्न चरणों पर सूचना और हामीदारी कौशलों के अभाव को देखते हुए इसके लिए तैयार नहीं है।

वे कहते हैं कि इस वर्ष में पहले मेरीन हल की दरों से प्रशुल्क हटाना (नब्बे के दशक के अंतिम वर्षों में व्यवसाय की विभिन्न श्रेणियों में प्रशुल्क मुक्ति के प्रगामी, छोटे उपाय भी) अनुभव प्राप्त करने के अवसर हैं।

वे निष्कर्ष निकालते हैं कि प्रशुल्क मुक्ति कैसे की जाए और उद्योग के सर्वोत्तम हितों को कैसे बनाए रखा जाए, गैर जीवन बीमा उद्योग के संबंध में विनियामक की एक मुख्य आसन्न चिंता है। वे कहते हैं कि विनियामक को मुद्दों की जाँच करने और उसे परामर्श देने के लिए अध्ययन समूहों का गठन करते हुए उद्योग में विशेषज्ञता का उपयोग करना चाहिए।

सेवानिवृत्त जीवन के लिए उनकी प्राथमिकता भारत या विदेश में अंशकालिक आधार पर कुछ विनियामक कार्य करना है और वे परामर्शदात्री भूमिकाओं की भी खोज कर रहे हैं। पर 38 वर्ष काम करने के बाद उनकी पहली प्राथमिकता है —“परिवार के साथ समय बिताओ!”

विनियामक का विकास एवं प्रसार होना चाहिए

जब **टी.के. बेनर्जी** ने आईआरडीए ज्वॉइन किया तो उन्होने पाया कि हर दिन कुछ नया सीखने की जरूरत है।

जब श्री टी.के. बेनर्जी ने भारतीय जीवन बीमा निगम में सेवा करने के पश्चात अगस्त 2003 के मध्य में IRDA में सदस्य (जीवन) के रूप में कार्यभार संभाला, तब उन्होंने यह पाया कि काम के लिए 'प्रतिदिन के ज्ञान' की आवश्यकता है।

4 अगस्त को कार्यालय को निर्दिष्ट करते हुए वे याद करते हैं कि विनियामक की जीवन अवधि में यह एक महत्वपूर्ण चरण था। विनियमन का लेखन चरण समाप्त हो चुका था और अब निगरानी की शुरुआत करने की तैयारी करने का समय था। "यदि हम यह काम अच्छी तरह नहीं करते, तो उद्योग का सही विकास नहीं होगा और बाद में चीजों को बदलना आसान नहीं होगा।"

किसी कम्पनी की वित्तीय शक्तियाँ और निवेश का संविभाग उसकी ऋण-शोध क्षमता जितना महत्वपूर्ण है पर यह बात भी महत्वपूर्ण है कि वे बाजार स्थल में किस प्रकार व्यवहार करते हैं। "इसका अनुमान करते हुए विनियामक एक अधिक महत्वपूर्ण भूमिका अदा करता है," वे टिप्पणी करते हैं।

वे एक उदाहरण के रूप में पिछले वर्ष की समाप्ति पर बिक्री में विपथनों

और मुख्य व्यक्ति बीमा पॉलिसियों को वापस करने को याद करते हैं। पॉलिसीधारक को आरम्भ में कई पॉलिसियाँ सौंपी गईं और हमने यह पाया कि बैंक प्रत्यक्ष रूप से प्रीमियमों का वित्तपोषण कर रहे थे। इसके अलावा अतिरिक्त इकाइयाँ छूट पर आबंटित की जा रही थी। यदि ऐसे दुरुपयोग को तुरन्त नहीं रोका जाता, तो इसके परिणामस्वरूप बाजार को नुकसान पहुँचेगा, इसलिए विनियामक को कठोर होना चाहिए।

उद्योग प्रभावशाली विकास दरों के साथ बहुत अच्छा कार्य कर रहा है पर इनके साथ कम प्रशंसनीय पहलू भी हैं, वे कहते हैं। वैयक्तिक प्रबंधकों पर बहुत अधिक दबाव है और वे कार्य निष्पादन दिखाने के लिए विपणन और प्रक्रियात्मक युक्तियों का सहारा लेते हैं।

"मुझे नीतियों द्वारा दिए जा सकने वाले निदर्शनों पर ध्यान दिए बिना इन पर प्रतिलाभ की उच्च दरों का वचन देने के द्वारा व्यापक कुबिक्री का डर है। इसका पता लगाना या

सिद्ध करना कठिन है। मैं सोचता हूँ कि हमें एक ऐसी बिक्री प्रक्रिया प्रलेखन प्रणाली की ओर कार्य करना चाहिए जो एक पारदर्शी रिकार्ड की व्यवस्था करेगी।"



हम नैगम एजेंट प्रणाली को सरल बनाने के संबंध में भी कार्य करते रहे हैं, जहाँ हमने उप-एजेंटों को नियुक्त करने जैसी पद्धतियाँ देखीं जिनका विनियम व्यक्त रूप से निषेध करते हैं, वे कहते हैं।

इससे वे विनियामक द्वारा प्रभावशाली निगरानी करने के लिए साधन सम्पत्ति पर पहुँच जाते हैं। वे कहते हैं कि प्क्। में संसाधनों की कमी है और विनियामक को इतना उदार होने की आवश्यकता नहीं है। “हमें अपने कर्तव्यों का प्रभावशाली ढंग से निर्वाह करने के लिए महत्वपूर्ण नगरों में कार्यालयों और पर्याप्त विशेषज्ञ कर्मचारियों के बारे में सोचने की आवश्यकता है।”

प्राधिकरण में अपने दो वर्ष के कार्यकाल की ओर मुड़कर देखते हुए श्री बेनर्जी जीवन बीमा परिषद को सक्रिय करने को याद करते हैं, जिसकी भविष्य की भूमिका एक स्व-विनियामक संगठन की भूमिका अदा करना होगी। “इस चरण पर पहुँचने में दो वर्ष लगेंगे,” वे कहते हैं, पर इसने यह निर्णय लेते हुए मुख्य व्यक्ति बीमा के दुरुपयोग को रोकने के मामले में अपनी क्षमता दर्शाई है कि ये केवल सावधि

पॉलिसियाँ होनी चाहिएं न कि इकाई से संबंधित।

एक अन्य पहल जिसमें वे संलग्न थे और जिसे वे संतोष के साथ मुड़कर देखते हैं – वह है एजेंटों की प्रशिक्षण प्रणाली को सरल बनाना। “एजेंटों का प्रशिक्षण एक बढ़िया विचार है पर इसने ऐसा रूप ले लिया कि प्रशिक्षण या परीक्षाओं में अधिक अनुशासन नहीं था। सभी संबंधित पक्षकारों ने इस प्रणाली की मंशा की विफलता में योगदान दिया क्योंकि उन्होंने व्यवसाय का विकास करने के लिए शीघ्र तैनाती के पक्ष में उचित रूप से प्रशिक्षित एजेंटों के महत्व की उपेक्षा की। निगरानी और निरीक्षणों के बाद इन कामों को नियंत्रित किया गया है और कुछ संस्थाओं का लाइसेंस मुक्त कर दिया गया है।”

उनके लिए संतुष्टि की एक अन्य बात लघु बीमा के लिए विनियमों का विकास रही है। “देश को एक ऐसे मंच की आवश्यकता है जिसपर लघु बीमा का विकास किया जा सके,” वे कहते हैं। एक ऐसी प्रणाली जो गरीबी की रेखा से कुछ ही ऊपर की जनसंख्या की आपदा से रक्षा करेगी।

जिस चीज पर वे निराशा के साथ देखते हैं, वह यह है कि कार्यस्थल की निरीक्षण प्रक्रिया अभी तक पूरी तरह स्थापित नहीं की गई है। “हमें पहले ही शुरुआत कर लेनी चाहिए थी और हमें पिछले मार्च की गलतियों जैसी कुछ गलतियों से बचना चाहिए था,” वे खेद व्यक्त करते हैं।

“हमारे यहाँ व्यापक निरीक्षण विभाग होने चाहिएं और हमें कुछ संसाधनों को बाहर सौंपना चाहिए और कुछ का अपने संगठन में ही विकास करना चाहिए,” वे सुझाव देते हैं।

उत्पादों के संबंध में वे इस बात को देखते हुए जीवन बीमा कम्पनियों को स्वास्थ्य संबंधी पॉलिसियाँ बेचने में समर्थ बनाने वाली कुछ पहलें देखना चाहेंगे कि एजेंसी के कार्यबल में खुदरा उत्पाद बिक्री की क्षमता है और वैयक्तिक ग्राहकों का नेटवर्क है। “यह अवसर एजेंसी के कार्यबल में ताकत फूँक सकता है,” वे कहते हैं।

श्री बेनर्जी ने सेवानिवृत्ति के बाद हैदराबाद में छह महीने बिताने के बाद कुछ पेशेवर कार्य करने की योजना बनाई है।

तबाही के बाद, बीमाकर्ता को अपना कार्य कर दिखाना है

एक बड़ी तबाही के बाद वह वक्त आता है जब एक बीमाकर्ता अपनी ईमानदारी और काबिलियत को प्रदर्शित कर बीमा उपभोक्ताओं पर अपना विश्वास बना सकता है, *पी. सी. जेम्स* कहते हैं कि किस प्रकार एक बीमाकर्ता विपत्ति काल में सूझबूझ के साथ अपना कार्य कर सकता है और अपने व्यापार में विस्तार कर सकता है।

एक प्राकृतिक विपदा का परिणाम काफी भयानक हो सकता है। ज़िंदगी की तबाही, संपत्तियों का नुकसान, आय का नुकसान साथ ही अन्य अतिरिक्त खर्च, इन सभी पर प्राकृतिक विपदा का काफी असर पड़ता है। अभी हाल ही में दक्षिण भारत में सुनामी ने कहर बरपाया। यह एक ऐसा मंजर था जैसे भगवान ने धरती के एक हिस्से पर अचानक युद्ध प्रारंभ कर दिया था। सुनामी का यह प्रकोप इतनी आसानी से नहीं भुलाया जा सकता है। यह एक कल्पना के परे दृश्य था, समुद्र ने सब कुछ अपने अंदर निगल लिया। इस प्रकोप से हुई हानि की भरपाई होने में काफी समय लग जाएगा तथा साथ ही काफी धन भी लगेगा।

अंतर्राष्ट्रीय बीमा समाज ने इस प्रकोप को काफी गंभीर माना है। बीमा कंपनियों को इस विपदा में मरे लोगों को ५०० मिलियन डॉलर से अधिक देने पड़े हैं। जहाँ बीमाधारक के छोटे समाज में जोखिम जागरुकता की कुछ कमी देखी गई, जो लोग इसके प्रति जागरुक थे, उन्होंने लोगों को इसके बारे में कुछ बताने में भी कोई रुचि नहीं दिखाई। बाढ़ हो, भूकंप हो या फिर सुनामी, बीमा कंपनियों को नई योजनाओं पर विचार करना होगा ताकि लोगों को इन दुखद समय में बीमा का कुछ लाभ मिल सके। बीमा को इसके लिए अपने जोखिम प्रबंधन में भी काफी बदलाव करना होगा।

बीमाकर्ताओं को हमेशा से ही यह मालूम रहा है कि यह उपमहाद्वीप प्राकृतिक विनाश का सामना करता ही रहता है, चाहे वह बाढ़ हो, भूकंप या फिर सुनामी। एक विशेष बीमा कवर जो लोगों को इन मुश्किलों की घड़ी में लाभ दे सके, के निर्माण की आवश्यकता है। इसके लिए जोखिम एवं प्रीमियम का पुनः आंकलन करना होगा और टैरिफ एडवाइजरी कमेटी इसे काफी सही तरीके से नियंत्रित कर सकती है। इस कवरेज के लिए लागू शर्तों का भी खुलासा होना चाहिए।

दंगे, हड़ताल एवं आतंकवाद उच्च श्रेणी के सामाजिक जोखिम प्रोफाइल है। बाढ़ का जोखिम, भूकंप एवं अन्य ऐसे उच्च श्रेणी के जोखिम हैं, जो प्रकृति द्वारा प्रदत्त है। परंतु बीमाकर्ताओं द्वारा इस श्रेणी के लिए किया गया कवर अपर्याप्त है।

वर्तमान में इन प्राकृतिक विपदाओं के लिए भारत में क्या स्थिति है? सुनामी में अपना सब कुछ तबाह कर चुके लोगों के लिए बीमा कंपनियों द्वारा क्या किया जा रहा है? भविष्य में बीमा कंपनियों के

एक बीमाकर्ता को तबाही के समय न सिर्फ लोगों को बीमा की रकम उपलब्ध कराने में जल्द से जल्द मदद करनी चाहिए, बल्कि यह उपाय भी किया जाना चाहिए कि यह सरलता से संपन्न होना चाहिए। इसके लिए बीमाकर्ता को पर्याप्त योजना तैयार करनी होगी।

लिए इसके लिए क्या योजनाएँ हैं? वे क्या कर सकती हैं? यहाँ एक विश्लेषण के माध्यम से इसके बारे में एक विवरण दिया जा रहा है।

तबाही के बाद लोगों की निगाहें सीधे बीमाकर्ता की ओर जाती है। लोग यह समझते हैं कि बीमा कंपनियाँ उन्हें नुकसान से बचा सकती है तथा वे लोग अपने द्वारा कराई गई बीमा रकम की प्रतीक्षा करने लगते हैं। प्राकृतिक विपदा की परिस्थिति में लोगों की मदद के लिए तत्काल कार्य करने वाली बीमा कंपनी बाजार में अपनी साख को बढ़ाती है तथा साथ ही बीमा उद्योग को भी बढ़ावा मिलता है। क्या बीमा कंपनियाँ उन उम्मीदों पर खरी उतर पाती हैं? एक बीमाकर्ता को तबाही के समय न सिर्फ

लोगों को बीमा की रकम उपलब्ध कराने में जल्द से जल्द मदद करनी चाहिए, बल्कि यह उपाय भी किया जाना चाहिए कि यह सरलता से संपन्न होना चाहिए। इसके लिए बीमाकर्ता को पर्याप्त योजना तैयार करनी होगी।

वे लोग जिन्हें भारत में बीमा विकास के चरणों के बारे में जरा सा भी याद है, उन्हें ज्ञात होगा कि, दंगों एवं हड़ताल के लिए किया गया बीमा कवर फायर पॉलिसी पर ही अतिरिक्त प्रीमियम था। कई बीमाधारकों ने इसे क्रय नहीं किया क्योंकि बीमा को एक अतिरिक्त खर्च के रूप में देखा जाता था न कि वित्तीय सुरक्षा की नजर से। देश में लगातार दंगे होने लगे। कई दुकानें एवं घरों को नुकसान पहुँचाया गया, इनमें से कई का रिस्क कवर नहीं था। तब सरकार के आदेश से इसे फायर कवर के साथ जोड़ा गया। इसके लिए फायर पॉलिसी को परिवर्तित किया गया। जब पंजाब एवं उत्तर-पूर्वी देशों में आतंकवाद सिर चढ़कर बोलने लगा तो बगैर किसी अतिरिक्त प्रीमियम के इसे फायर कवर के साथ जोड़ दिया गया। 11 सितम्बर की घटना के पश्चात इस योजना को हटा लिया गया और बीमा धारक को इस योजना का फायदा उठाने के लिए अतिरिक्त प्रीमियम देने को कहा गया। इससे बीमाधारकों को काफी धक्का पहुँचा और उन्हें लगा कि बीमा कांटेक्ट को क्या इस प्रकार आसानी से तोड़ा जा सकता है। अतः इसकी विश्वसनीयता पर सवाल उठाने शुरू हो गए। मार्च 2001 तक बाढ़ एवं चक्रवात से हुए नुकसान के लिए फायर पॉलिसी पर ही अतिरिक्त प्रीमियम दिया जाता था। मार्च 2001 से इसे फायर प्रीमियम के साथ ही शामिल कर लिया गया, यानि अतिरिक्त प्रीमियम देने की आवश्यकता नहीं रही। यहाँ बीमाकर्ता ने अपने बीमाधारकों की सुरक्षा एवं फायदे को ध्यान में रखा ताकि हर किसी को वित्तीय सुविधा मुहैया करवायी जा सके। इस प्रकार समाज को इसका

फायदा मिलना प्रारंभ हो गया। सुनामी आने का प्रमुख कारण भूकंप है। तो क्या इसका कवर सिर्फ उन लोगों को मिलना चाहिए, जिन्होंने भूकंप के लिए कवर लिया हुआ है। जो लोग बाढ़ के लिए कवर कराए हैं, उन्हें क्या मिलेगा। क्यों नहीं प्राकृतिक विपदाओं से हुई हानि को एक ही वर्ग में रखा जाए। हानि चाहे बाढ़ से हुई हो, या फिर भूकंप से, या ज्वालामुखी के फटने से या फिर अन्य प्राकृतिक आपदा। इनके लिए एक ही बीमा कवर होना चाहिए। सुनामी क्या है- भूकंप, बाढ़ या फिर ज्वालामुखी विस्फोट ?

एक बीमाकर्ता ऐसी परिस्थितियों में क्या कर सकता है ?

विपत्ति के समय संवाद

प्राकृतिक विपदा के समय सबसे आवश्यक कार्य है पीड़ितों से बातचीत। किस प्रकार आप उन्हें सहायता प्रदान कर सकते हैं। सभी लोगों को बीमा का लाभ मिले इसके लिए मीडिया को भी पर्याप्त भूमिका निभानी होगी। बीमाधारक को जोखिम कम करने के उपाय बताना तथा साथ ही क्लेम कैसे किया जाए, यह बताना आवश्यक है। उनके अधिकारों एवं उद्धारदायित्वों से उन्हें अवगत कराना होगा। इससे बीमा में उनका विश्वास बढ़ेगा।

संकट दल का गठन

बीमाकर्ता को एक ऐसे दल का गठन करना होगा जो विपत्ति के समय लोगों को सहायता प्रदान कर सके। इसके लिए जो महत्वपूर्ण बातें हैं, उनमें स्थानीय क्षेत्र की पर्याप्त जानकारी तथा दल में सही लोगों का चयन होना है। जनता को भी इसके बारे में बताना होगा ताकि जरूरत पड़ने पर वो भी मदद में अपना सहयोग दे सकें।

तत्काल कदम उठाना

विपत्ति आने के बाद जितनी जल्दी उससे बचने के उपाय किए जाएँ, उतना ही अच्छा है। एक बीमाकर्ता के पास उस समय बीमा के सारे दस्तावेज हों, यह आवश्यक नहीं है। बीमा कंपनियों को एक कैंप ऑफिस बनाना होगा। सभी नुकसान का जायजा लेना होगा तथा लोगों को इसकी जानकारी प्रदान करनी होगी।

दायित्वों का बँटवारा

बीमा कंपनी को कार्य विभाजित करने होंगे जैसे वित्तीय प्राधिकरण को क्लेम का निपटारा, सर्वेक्षणकर्ता के सर्वेक्षण पर क्लेम का भुगतान, अन्य बीमा कंपनियों के साथ सहयोग, एजेन्ट, सर्वेक्षणकर्ता तथा कर्मचारियों को दिशा-निर्देश जारी करना, पर्याप्त फंड का इंतजाम ताकि क्लेम का समय पर भुगतान किया जा सके, इत्यादि का बंदोबस्त करना होगा। साथ ही राहत कार्यों का सही संचालन भी आवश्यक है।

वर्तमान में इसका निपटारा कैसे किया जाए ?

पिछले सालों में अग्नि से हुई दुर्घटनाओं के क्लेम में कमी आई है और इसलिए प्राकृतिक विपदाओं को इसमें शामिल करने से बीमा कंपनियों को इससे किसी प्रकार के नुकसान होने की संभावना

सभी लोगों को बीमा का लाभ मिले इसके लिए मीडिया को भी पर्याप्त भूमिका निभानी होगी। बीमाधारक को जोखिम कम करने के उपाय बताना तथा साथ ही क्लेम कैसे किया जाए, यह बताना आवश्यक है।

नहीं है। अतः यह भूकंप है या फिर बाढ़, इसके बारे में वाद-विवाद करने से अच्छा है कि इसके कानूनी पक्ष की ओर ध्यान दिया जाए।

यदि इन आधारों पर बीमाकर्ता क्लेम का भुगतान करने से मना कर दे तो क्या इससे बीमा कंपनियों की साख पर कोई असर नहीं पड़ेगा ? आज बीमा कंपनियाँ इस बारे में ज्यादा बात नहीं कर रही हैं। वे लोग जिन्होंने बाढ़ का कवर लिया हुआ है, उन्हें क्लेम का भुगतान नहीं किया जा रहा है। बाजार को इस पर अपनी प्रतिक्रिया देनी होगी। और जितनी जल्दी यह होगा उतना ही बीमा कंपनियों एवं बीमा

क्षेत्र के लिए फायदेमंद होगा।

कई लोग यह सोचते हैं कि सरकार उनकी मदद के लिए आगे आएगी और उन्हें सुरक्षा प्रदान करेगी। अब चुंकि बाजार में उदारवाद आ गया है। निजी बीमा कंपनियाँ भी बाजार में हैं, वर्तमान स्थिति काफी भिन्न है। जहाँ सुनामी ने आम जनता को काफी नुकसान पहुँचाया है, वहीं बीमा कंपनियों को एक अवसर मिला है कि वे अपने जोखिम प्रबंधन का पुनः आंकलन करे और जनता को यह विश्वास दिलाए कि बीमा कंपनियाँ उनकी वित्तीय सुरक्षा के लिए सदैव तैयार हैं। यह कार्य लोगों के दिमाग से सुनामी की यादें निकालने के लिए ही करना होगा।

टैरिफ एडवाइजरी कमेटी (टीएसी) के लिए कार्य

टीएसी को भी इस दिशा में काफी कार्य करने होंगे। एक आम आदमी किस प्रकार जाने कि उसके लिए कौन सा कवर उपयुक्त है। भारत में प्राकृतिक आपदाएँ काफी सजग हैं और कभी भी देश के किसी भी कोने में इसका सामना करना पड़ सकता है, चाहे वह गुजरात का भूकंप हो या फिर हाल ही में सुनामी की वजह से हुई तबाही। जान-माल का नुकसान का आंकलन करना काफी क्लिन्न कार्य है, और टीएसी इस जोखिम का आंकलन करना होगा ताकि भविष्य में आम जनता को इन नुकसान से हुई भरपाई मिल सके और वे उन्नत जीवन बीता सकें। केवल जोखिम का आंकलन करना ही महत्वपूर्ण नहीं है। यह भी तय करना होगा कि पीड़ित लोगों को यह सहायता तत्काल मिल सके। इसमें देर लगने से इसका वह फल नहीं मिल पाएगा जो मिलना चाहिए।

हम देखते हैं कि कई ऐसे क्लेम हैं, जिनका अभी तक भुगतान नहीं किया गया है। ऐसे में नए क्लेम का निपटारा जल्द हो सकेगा, यह विश्वासनीय नहीं है। फायर के साथ प्राकृतिक विपदाओं के कवर को लागू करने की आवश्यकता है।

लेखक आईआरडीए में कार्यकारी निदेशक (गैर-जीवन) के पद पर कार्यरत हैं। उपरोक्त विचार उनके स्वयं के हैं।

A Few Ways Forward

- The state of voluntary health insurance in India

A detailed study of the existing data on Mediciam reveals that there is ample room for growth in the nation's health insurance market, and tapping it requires good planning and concrete efforts, write *Indrani Gupta* and *Mayur Trivedi* in the third and concluding part of their article.

The first two parts of this article discussed how India can look to achieve the goal of adequate health coverage for its population, and how efficient databases are a prerequisite for the growth of the health insurance market. The third and concluding part examines the impact that a health insurance policy – Individual or Group – makes on the financial status of the household. It also analyses the existing health insurance scenario based on available data.

To understand whether and how households benefit from buying health insurance policies, we need to analyse the premiums, sum insured and claims. A few points of clarifications are required before we turn to the analysis.

Firstly, to understand how the claims vary according to premiums, we need to restrict the data to only those who have completed one year's policy; else the numbers would mis-state the correlation of claims to premiums. Only 24 percent of the group and 37 percent of the individual policies in the dataset had been "complete", in the sense that these are the policies that had the duration of one completed year. The analysis on claims is therefore restricted to these policies only.

Secondly, there are two levels in which the analysis should be done: Individual and Group, because the differences between these reveal some interesting results pertaining to policies of insurance companies.

Finally, the analysis can be further done at the level of either households or individuals; in addition, for the group policies, there can be an added angle, to see the per capita group (eg. companies) variables as well. We will indicate below wherever relevant, the various aggregates being used in the analysis.

Further, slightly less than 3 percent

of the completed Group policies and less than 5 percent of the completed Individual policies had put in claims. It would be interesting to compare the rate of morbidity from National Sample Survey (NSS) data, to verify whether the percentages mentioned are close to the actual rates of morbidity in a randomly selected sample of households. The NSS data indicates that in urban India, the

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There is a general tendency to go in for insurance only when the health risks to the self are becoming clearer.

This may be rational behaviour on the part of the individuals, but there can be incentives built in the premium structure for earlier insurance and family coverage, that can attract younger individuals and their families.



morbidity rate was around 2 percent in 1995-96, with a range of 1-3.5 percent depending on the income class of the individual (Gupta, 2004). This indicates

that the Mediciam data on claims is very much within reasonable limits.

What kind of burden do households face from ill health, especially hospitalisation? The data of 1995-96 reveal that per capita annual expenditure on acute illnesses was around Rs. 2,000 for 1995-96 (Gupta, 2003). The price rise between these 10 years in urban non-manual employees is about 60 percent. Thus, per capita expenditure in today's prices should be around Rs. 3,200.

Keeping these statistics in mind, we turn to Table 4, which shows per capita individual and household premium and sum insured for both Group and Individual policies for all the cardholders.

If we look at the household size, which really means the average number of individuals who are covered in a household, it is 2.5 for Individual and 2.8 for Group policyholders. The average household size in India is five, which immediately indicates that there is a lot of scope for expanding coverage. These numbers also indicate that individual policies are being undersold to a greater extent than Group policies. This conclusion is even more valid if the average household size in the general population is greater than the size calculated based on the employees of the companies that go in for Group insurance. While it cannot be

Table 4: Per capita Premium and Sum Insured in Mediciam

	Per capita premium		Per capita sum insured		Size
	HH	Individual	HH	Individual	HH
Group	3,194	1,150	5,11,009	1,83,984	2.78
Individual	3,164	1,282	2,06,830	83,831	2.47
All	3,179	1,216	3,58,920	1,33,908	2.63

empirically verified, it is probably true that given the salary structure and the kind of education and occupation of the employees, the family size on an average for these employees is lower than the national average. Also, the “family floater” option is only available in the case of Group insurance, and it is probably ensuring that insured employees are able to cover most of their family members. This implies that there is a much greater scope of expanding insurance in the Individual category relative to the Group category.

Another point to note here is that the age pyramid presented before indicated that individuals are, on an average, buying insurance at a much later stage in life, unlike individuals who are being covered under Group policies. This, together with a lower family size in case of Individual policies, indicates a general tendency to go in for insurance only when the health risks to the self are becoming clearer. This may be rational behaviour on the part of the individuals, but there can be incentives built in the premium structure for earlier insurance and family coverage, that can attract younger individuals and their families.

The table shows that in case of the Individual policies, the households are paying a total premium of Rs. 3,164 on an average annually, and insuring on an average Rs. 2.07 lakh. These numbers are Rs. 3,194 and Rs. 5.1 lakh, respectively, for Group policies. Another way of looking at it is not by households, but by individuals. Per capita premium is Rs. 1,282 for the “Individual” category and Rs. 1,150 for “Group”. The NSS statistics above indicated that the per capita household expenditure on acute illnesses is about Rs. 3,200, which means that on an average, in the system, individuals are saving Rs. 1,918 by taking insurance. This picture is going to be clearer when we look at average claims. Of course, the actual individual calculations of risks and benefits are obviously done differently, but taking a macro perspective, it seems clear that there are benefits of being insured.

It is interesting to note that the sum insured is much greater for Group policies than Individual policies, though the per capita premiums are lower. This indicates the benefits of group pooling, which is enabling the per capita premiums to be lower, and which is being somewhat lost to the individual householders who are going in for health insurance.

From the supply side, there is another practical reason why the group health premiums are lower than individual premiums. In India, the non-health insurance businesses, like fire, are called “tariff” business, i.e. the Tariff Advisory Committee lays down the tariff rates for some of these general insurance products, and these are the

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From the perspective of the insurance company, it does not seem as though the health insurance business is a loss-making one; in fact, it is quite clear that if the volume of business is increased, the total profits could be substantial.

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major sources of profits for the insurance companies. In order to attract private sector companies to give them business in these general insurance products, insurance companies often offer health

insurance group policies at attractive terms (lower premiums) as “accommodation” business (Kalyani, 2004; Segal, 2004). This, of course, is not an option available to individual policyholders, who therefore lose out on both counts – lack of pooling and non-market related reasons of lowered premiums.

Looking at it from the point of view of claims, Table 5 indicates the average claim and grant amounts for individual policies, for only completed policies. This is not presented for the Group policies because of huge selection bias problems that occurred due to primarily elimination of errors in the dataset.

As can be seen, the average claim amount is Rs. 13,148 for individuals and Rs. 34,981 for households. The claims amounts are, however, what the policyholder puts in; for example, for the Individual policies, the insurance companies on an average grant Rs. 10,929 - a 17 percent reduction. In terms of numbers, 12 percent of the individuals put in claims and 9 percent were found eligible for reimbursement. The rejection rate of 33 percent (the percentage of claims that were rejected out of total claims) is quite moderate and, if compared to other insurance schemes, seems reasonable, as will be discussed below.

How do these numbers differ across gender? The NSS data reveals that on an average female expenditure on acute illness is 10 percent less than the expenditure incurred by males. This most probably does not indicate a true

Table 5: Claims, grants and premiums in Medicaclaim

	HH	Individual
Average claim amount	34,981.65	13,148.03
Average grant amount	29,116	10,929
Average per capita premium for completed policies	2,842	1,195
Ratio of claim amount to premium	12,986	
Ratio of grant amount to premium		
Rejection Ratio	33	

difference in morbidity-related expenditure, but a gender difference in health-seeking behaviour. It is likely to be true given the status of women in India that lack of health coverage is likely to affect the health seeking behaviour of women more than men. To that extent, greater efforts need to be made to include women in health coverage. The per capita premiums could not be calculated by gender in the Individual data since the premiums are consolidated for the family. However, we can look at the claims and grants data by gender to explore whether there are any differences.

Table 6 indicates the age and gender distribution of individuals in the sample, and those who submitted claims. The rejection rate – taking into account the grant amount – has also been calculated by gender.

The table indicates that, on an average, there are 10 years between the time of taking policy and putting in claims for both the genders. The average age of insured individuals and those who put in claims do not differ much between males and females.

As for the rejection rate, there is, in fact, a lower rejection rate for females than for males, indicating no particular tilt against women, as may be assumed (52 percent of males and 48 percent of females in the sample had put in a claim).

The average premium for completed policies is Rs. 1,195, compared to the average claim of Rs. 13,148 for Individual policies. The Third Party Administrators (TPAs) are paid 5.5 percent by the insurance companies to handle the insurance business; if this cost is deducted from the premiums, and an additional 10 percent is further deducted as administrative and handling costs for the insurance company, it can be shown that the health business can still earn about 2-3 percent profits (as a percentage of total premiums). The fact that the 'grant amount to premium ratio' is 86 percent also bears this out.

Gender	Mean Age		Grant amount	Claim amount	Rejection rate
	All individuals	Individuals with claims			
Male	37	48	3,55,85,427	5,62,01,187	37%
Female	36	46	3,00,12,501	4,18,17,408	28%
All	37	47	6,55,97,928	9,80,18,594	33%

It would be interesting to compare these results with the results from a few major partnership-based schemes. In Table 7 we look at two community health insurance schemes, SEWA and BAIF, both of which are being run in

The table indicates that the per capita premium is as low as Rs. 30 in SEWA and as high as Rs. 2,034 for the J & K scheme. The total volume covered differs across the schemes, but it is clear that a very low premium is able to attract a large volume of business. While the per capita claim figures are not very revealing by themselves due to the different designs of the schemes, the percentage of policyholders putting in a claim ranges between about 1 percent to 7 percent, which is close to the numbers indicated by the Mediclaim data. It can safely be assumed that less than 10 percent of policyholders will put in claims at any given period.

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Results from various partnerships indicate that initiatives are able to meet the demand for claims of the insured while not being loss making from the insurers' perspective.
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professional partnerships with insurance companies. In addition, we also look at the schemes initiated by the Jammu and Kashmir government for its employees, and is essentially offering a tailor-made group Mediclaim scheme from NIC.

In the case of Mediclaim data of NIC, while the claims-to-premium ratio is about 129 percent, the grants-to-premium ratio is 86 percent. This ratio is much less for SEWA and J&K policy, but very similar for BAIF. The rejection ratio is also quite high for the first two schemes, whereas for NIC it is much less at 33 percent. These different numbers indicate that there are several

	SEWA ¹ (1994-2000)	J & K govt. employee group Mediclaim (2003-04)	BAIF scheme ² (2003-04)
Volume	2,28,572	51,617	909
Per capita premium	30	2,034	178
Per capita claim amount	2,037	43,772	2,306
% Putting in claim	0.8	2.3	7.2
PC grant	1,016	37,416	2,245
Ratio of claim amount to premium %	57	51	94
Ratio of grant amount to premium %	25	28	86
Rejection Ratio %	55	46	9

scenarios possible with insurance, but also reflect the positive side of Medclaim, which is that it is able to meet the demands for claims for a majority of its policyholders. However, it should be kept in mind here that while the details of the SEWA scheme are available over a period, the other two schemes are recent initiatives. It is essential to document such recent innovations on a continued basis to enable empirical analysis over time.

What do these various strands of results indicate?

- ◆ Firstly, the NSS data revealed an annual individual expenditure of about Rs. 3,200. Given that the premiums are much lower than these, it makes sense for households to go in for insurance.
- ◆ From the perspective of the insurance company, it does not seem as though the health insurance business is a loss-making one; in fact, it is quite clear that if the volume of business is increased, the total profits could be substantial.
- ◆ The age and gender structure, as well as the size of the families covered, indicate that there is a huge potential to expand the health insurance business in India, especially among householders.
- ◆ Results from various partnerships indicate that such initiatives are able to meet the demand for claims of the insured while not being loss making from the insurers' perspective.

This underutilised potential and scope for a win-win situation from both the perspective of the policyholder and insurance company brings home another point: can the government use this potential in any way to encourage further expansion of voluntary insurance and, if yes, what kind of initiatives can it undertake?

It has been argued elsewhere (Gupta and Trivedi, 2004) that there are many ways that the government can promote increased coverage in India. One key

method is to form productive partnerships between insurance companies, NGOs and the government, whether local, state or central.

While it is clear that there are greater incentives for group insurance, from the demand side, it leaves out those outside this kind of formal sector employment. It also leaves out those not working, students, the elderly, etc. The aim should be to cover entire communities, so that risk and income pooling are maximum. Since social health insurance is limited by the extent of organised sector employment, and community health insurance without outside support has problems of sustainability, using the potential of voluntary health insurance may be one

One of the instruments that IRDA can actually use is mandated coverage, wherein the companies can be directed to undertake a minimum amount of health business.

of the few ways forward. To do this, it is important that a few key stakeholders form productive partnerships.

There are already examples of some prominent partnerships that are now being discussed as possible models of replicable schemes. These include NGOs like Karuna Trust (Karnataka), SEWA (Gujarat), Student's Health Home (Kolkata), Seba Hospital (Kolkata) and Rag Pickers' Scheme (Pune). There are other such partnerships as well, and the important point to note is that often these partnerships are beyond merely "public-private" but can be termed "private-private" or "public-public", depending on who the stakeholders are.

For example, SEWA is collaborating with ICICI – a private sector insurance

company – to extend insurance to women. The Rag Pickers' Scheme is a collaboration between the Pune Municipal Corporation and New India Assurance Company, a public sector company. It is imperative for the policymakers to focus attention on these and other not-so-prominent success cases from the point of view of replicability and scalability so that greater coverage can become a reality rather than a moving target. From the demand side, a stepped up effort at IEC promoting the usefulness of health insurance is required, and once possible initiatives are charted out, these need to be widely publicised to achieve the desirable results.

A summary and some conclusions

The paper looked at the growth of voluntary insurance in India, and used the Medclaim data of the National Insurance Company to arrive at some key conclusions:

- ◆ Health coverage is still restricted to about 10 percent of the population in India, and there are limits to expansion of Social Health Insurance, social security based health coverage, and stand-alone Community Health Insurance.
- ◆ Extending health cover to the entire population is one of the major ways of achieving the Health for All objective because it removes an important barrier to health seeking behaviour.
- ◆ The growth in voluntary health insurance has been significant over the past several years, and it is clear that the potential for growth in health insurance is immense.
- ◆ The expansion has been significant in both the public and private sector insurance companies, but the private sector growth rates have been much higher

However, as for market share, the four public sector companies still corner the greater part of the health business.

- ◆ However, health business is still a small part of the total non-life insurance business in India.
- ◆ The Medclaim data reveals that the bulk of the policyholders are in the age range of 40-59, which indicates both a likely adverse selection problem from the insurance companies' perspective and an inadequate demand for insurance from the younger age cohorts.
- ◆ The age distribution differs across Individual and Group policies significantly, with the Individual policies being much more older-cohort based than the Group policies, where the age distribution is more or less uniform across 20-29, 30-39 and 40-49 age categories, indicating that the Group policies are able to take advantage of pooling across risk and income categories, as is desirable.
- ◆ The gender distribution indicates that females are probably still passive recipients of insurance, being covered mostly through their husbands. This phenomenon is much less visible in the case of Group policies, as is expected.
- ◆ The data revealed that, on an average, a much lower household size is operational within policyholders than in the population. Slightly less than three members of a household are being covered by insurance on an average, compared to a household size of greater than five in India. The average size for Group policy is, in fact, slightly lower compared to that for Individual policy.
- ◆ Per capita premium and sum insured are slightly lower in Individual compared to Group policies.
- ◆ Per capita individual premium for Individual policies is Rs. 1,282 per annum; the NSS data indicates that the annual expenditure in the same year could be Rs. 3,200 per capita, indicating a substantial saving by individuals (and therefore

households) if they go in for health insurance.

- ◆ An analysis of the claims and grants data indicated that the grant to premium ratio is around 86 percent, indicating reasonable profit for the insurance company from health insurance.

What are the policy implications of these sets of results? The main result seems to be that while health insurance is growing significantly, it is still much below the potential market it can capture. While the individuals are clearly going to benefit from buying insurance, it is still not a spontaneous demand, and there are hardly any incentives built into the current product

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Since social health insurance is limited by the extent of organised sector employment, and community health insurance without outside support has problems of sustainability, using the potential of voluntary health insurance may be one of the few ways forward.

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that will make it attractive to younger people, the elderly or the women. It is clear that individual householders do not see much merit in buying health insurance, and do so only when they perceive tangible health risks.

The insurance companies clearly stand to gain by expanding the market and can offer even lower premiums if they are able to attract more households and individuals to the market. Tailor-made schemes with specific incentives to attract various segments of the population are clearly indicated as a business strategy, with benefits that can be distributed to the policyholders by

way of lower premiums.

This strategy is also useful viewed from the perspective of the country, where lack of sufficient health coverage seems to be hindering the achievement of the Health for All objective.

One of the main expectations of the opening up of the insurance sector in India was that health insurance could grow and become a viable option for a majority of Indians. However, this has not happened. It seems that the initial momentum with the introduction of TPAs has been lost, and health insurance business has again taken a back seat. The share of health in total non-life business was about 5 percent in 2000-01 and is at present only about 10 percent, showing a very modest growth. This is unfortunate indeed, and reflects on the lack of policy coherence around health insurance issues in India.

One of the instruments that IRDA can actually use is mandated coverage, wherein the companies can be directed to undertake a minimum amount of health business. For example, the IRDA can also think in terms of the approach adopted in the case of rural/social sector insurance businesses, wherein minimum business targets have to be achieved (Gupta *et al*, 2004). Similarly, it can also mandate that a certain percentage of total business be health, or even better, state the allocation of the mandated health insurance across different sectors (rural/urban).

The Universal Health Scheme was a limited attempt towards this, though without any directives on quantity or volume. However, this scheme has clearly not taken off. It is contended that if the product is consumer friendly in other aspects, as well as low cost, it is bound to attract business. A reasonable, well thought out product can then be developed and marketed through insurance companies, which can happen with some initial compulsory initiatives on the part of IRDA/government, but will bring with it some necessary innovations.

One such innovation, which can exploit this huge untapped potential, is productive partnerships among insurance companies, community based organisations and different levels of government. There are currently several such instances of partnerships, where the main beneficiaries are communities, who get low cost health insurance. However, such partnerships need to be studied carefully, from the perspective of costing and subsidies involved, as well as from the operational and financial feasibility angle.

Another point that may be critical in the scaling up of such innovative products is the reach of insurance companies in rural and other remote areas. Whereas the life insurance products are different from health insurance products, the Life Insurance Corporation (LIC) does have a tremendous network that can be used to distribute newer and better health insurance products as well. At present, LIC offers Critical Illness policies for a few major illnesses. LIC can however, also be mandated to sell a certain volume of health insurance product as well. Needless to say, this and other such newer initiatives would require IRDA to take another look at its current rules

and regulations governing the insurance business in India.

Finally, an important point to note here is the urgent need for a standardised database on insurance in India, across insurance companies, which should include proper documentation of all the partnerships between insurance companies and NGOs/CBOs/state governments. IRDA should proactively set up processes in

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place, so that it may act as a clearing-house for such information. Currently, state level information on collaborative

schemes do not always percolate down even to the head offices of insurance companies.

The insurance companies also gain by being able to expand volume, and the policymakers are also able to move towards their goal of greater coverage. Till the time the country decides to scale up social security or some form of social health insurance, it is imperative for it to explore alternative channels; the presence and growth of the voluntary health insurance sector offers a window of opportunity to do so, if the right moves are made at the right time.

Indrani Gupta is a Professor and Head of the Health Policy Research Unit and Mayur Trivedi is a Consultant at the Institute of Economic Growth Delhi. Support for this research was provided by the Center for Global Development's Global Health Policy Research Network, a programme funded by the Bill & Melinda Gates Foundation. The authors wish to thank the National Insurance Company for providing access to its database and extending cooperation in the research.

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Report Card: GENERAL

G. V. Rao

August Revival; Growth up 21%

Performance in August 2005

August 2005, when the general insurance industry recorded a premium accretion of Rs. 277 crore (20.7 per cent growth for the month) has been a vast improvement in premium growth over July 2005 of Rs. 183 crore (11.6 per cent growth).

The new players during 2005 seem to have established a pattern of cornering over 80 per cent of the new premium growth of the market in almost every month. In August 2005 their accretion of Rs. 215 crore is about 83.5 per cent of the market gain of Rs. 277 crore; in July 2005 their share of Rs. 148 crore of Rs. 183 crore was 81 per cent.

The four established players, it is obvious, have more or less settled at contributing only around 20 per cent to the new market premium. In August 2005 they contributed about 20.5 per cent and in July 2005 it was 19 per cent.

Such a dominant growth of new business in each succeeding month by the new players has pushed up their market share to 26 per cent at the end of August 2005 as against 18.7 per cent up to August 2004. The improvement in their overall market share by over seven per cent in fiscal 2005 so far is indeed remarkable.

ICICI, Bajaj and IFFCO together alone among the thirteen companies, have contributed about Rs. 180 crore (65 per cent of the total accretion of Rs. 277 crore) during the month of August 2005. Cumulatively, as at the end of August 2005, their contribution of Rs. 727 crore of the total accretion of Rs. 1,160 crore of the market works out to about 63 per cent, highlighting their dynamism. The competition for new business growth thus seems to be emerging from these three players, setting the pace for the rest of the market.

GROSS DIRECT PREMIUM (within India) AUGUST, 2005

(Rs.in lakhs)

INSURER	PREMIUM 2005-06		PREMIUM 2004-05		MARKET SHARE UPTO AUGUST, 2005	GROWTH % YEAR ON YEAR
	FOR AUGUST '05	UPTO AUGUST '05	FOR AUGUST '04	UPTO AUGUST '04		
Royal Sundaram	3,900.00	19,020.00	2,406.00	13,131.00	2.17	44.85
Tata AIG	5,030.99	25,330.37	3,412.23	21,132.28	2.89	19.87
Reliance General	886.25	6,609.82	1,135.16	7,364.89	0.75	-10.25
IFFCO-Tokio	6,165.63	35,037.57	2,689.41	20,233.39	4.00	73.17
ICICI Lombard	13,044.91	70,454.83	5,004.78	33,736.03	8.04	108.84
Bajaj Allianz	12,572.38	53,863.69	6,141.63	32,740.79	6.15	64.52
HDFC Chubb	1,785.04	7,765.68	1,347.45	6,666.83	0.89	16.48
Cholamandalam	1,612.44	10,708.12	1,374.60	7,529.33	1.22	42.22
New India	35,373.00	1,87,646.00	30,475.00	1,70,786.00	21.41	9.87
National	28,202.87	1,49,950.19	29,495.83	1,57,883.55	17.11	-5.02
United India	24,437.00	1,38,964.00	24,087.00	1,35,620.00	17.11	-5.02
Oriental	24,391.00	1,49,209.00	22,635.00	1,33,675.00	17.02	11.62
ECGC	4,145.43	21,941.44	3,672.12	19,980.38	2.50	9.81
TOTAL	1,61,546.94	8,76,500.71	1,33,876.20	7,60,479.47	100.00	15.26

During August New India, among the established players, shone bright with an accretion of Rs. 49 crore and a growth of 16 per cent. Oriental with Rs. 18 crore increase ranks next. National Insurance has maintained its usual monthly fall in business highlighting the changed strategy of dropping unprofitable business segments.

ICICI with about Rs. 81 crore, Bajaj with Rs. about 64 crore and IFFCO with about Rs. 35 crore accretion have set the market challenges for new business development in August 2005.

National Insurance and Reliance among the thirteen players have dropped their renewal premiums during August 2005. A growth rate of over 20.7 per cent during the month is a highly satisfactory situation for the market as a whole.

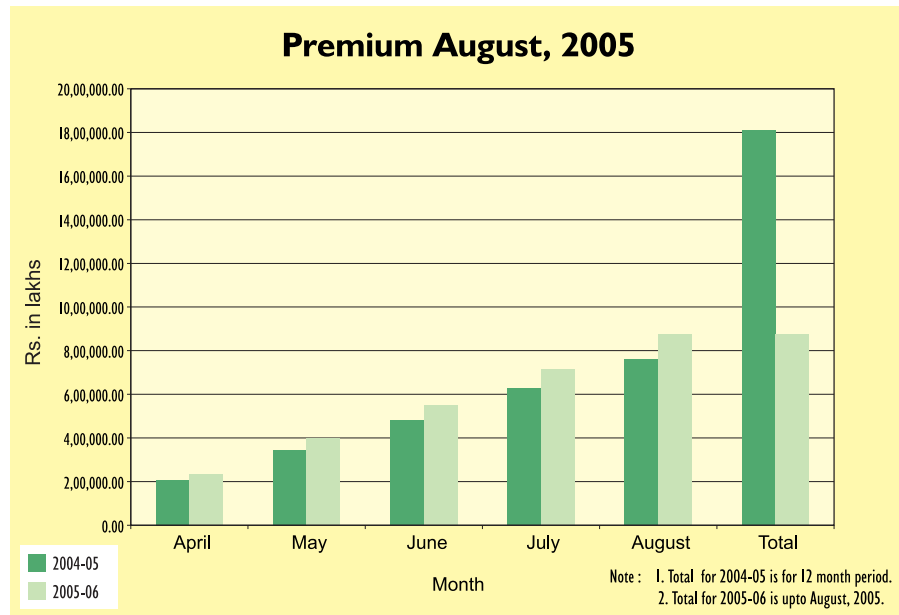
Performance up to August 2005

The overall accretion up to August 2005 is about Rs. 1,160 crore (15.26 per cent growth), with the new players adding Rs. 862 crore (60.5 per cent growth over last year) and the established players adding Rs. 298 cores (4.8 per cent growth over last year).

The new players have contributed 74.3 per cent to the total accretion of Rs. 1160 crore at the end of August 2005; it was 73.4 per cent at the end of July 2005.

Again, the three dominant players for this market growth are, ICICI, Bajaj and IFFCO, who together account for an accretion of Rs. 726.4 crore (62.6 per cent of the overall market growth of Rs. 1,160 crore at the end of August 2005).

New India with an accretion of about Rs. 169 crore (9.87 per cent growth), Oriental with Rs. 155 crore (11.6 per cent) and United India with an accretion of Rs. 33 crore (2.5 per cent) are spearheading the market developments for the established players. ECGC with a growth of about 10 per cent is finding the going tough.



Situation of established players

The established players appear to be finding it difficult to maintain an adequate monthly momentum to sustain their past growth rates and seem to be more or less steady at a growth rate of five per cent overall.

With the market growing at about 15 per cent and their own growth rates hovering around five per cent, it is not a good enough situation for them to be in; but the competitive environment they are faced with seems to have overwhelmed their zeal for premium growth, despite their vast superiority in infrastructure of offices, a huge trained manpower and a heavily decentralised set up in underwriting and claims areas – the aspects that new players find difficult to compete with.

What is holding them back from making the market more vibrant is their current disinclination to pioneer the business waiting to be tapped in the unorganised personal and rural sectors. This opportunity is huge, and is waiting lying at the bottom of the pyramid, and

moreover they are better equipped to capture it. As long as their current strategies are targeted only towards retentions of existing accounts and their natural growth developments, the growth rate of five per cent will remain the only possibility for achievement. Setting new directions for business growth is their urgent need.

Deepening and widening the market by sale of new covers and spread of insurance awareness and designing affordable covers for the rural areas are clearly the goals that require their attention. Customers should perceive improvements in customer service by harnessing technological developments and refining work processes. It is time their customers, whose business profiles and expectations have dramatically changed, are wooed more intensively for their patronage. It is bound to happen; but the question is will it happen sooner?

The author is retired CMD, The Oriental Insurance Company.

LIC goes to EU

Life Insurance Corporation has reportedly formulated a three-pronged strategy to expand its presence in Europe, including a direct entry or through joint ventures. The country's largest insurer is also eager to "co-brand" some of its insurance and pension product with European players to enter that market, Mr. K. Sridhar, Managing Director, LIC, has reportedly said.

"We have three models for entering EU. One is direct entry. Second is through a joint venture with a local partner. The third is to operate as broker of a local company," he was quoted as saying.

LIC, which is perhaps the largest insurer in terms of number of policies now at over 16 crore, has decided to increase its foothold in EU despite the fact that it is a matured market and is dominated by all the global majors. It is now present only in the UK, but is keen to enter other European nations where there are growth opportunities.

Three-member panel to probe ONGC Mumbai High accident

Coinciding with Oil and Natural Gas Corporation (ONGC) securing an insurance claim of Rs. 762 crore for the platform lost in the Mumbai High fire, the Central Government has announced a high-level committee to probe the incident, it is reported. Headed by Mr. T. N. R. Rao, former Petroleum Secretary, the three-member committee has been given six months to submit its report on the accident involving ONGC's Mumbai High North (MHN) processing platform.

Over 380 personnel were on the platform, on a supply vessel and on a nearby drilling rig when the accident took place. While 361 personnel were rescued, 11 were confirmed dead and an equal number were missing.

The probe committee includes Major General (Retd.) S. C. N. Jatar

(former CMD of Oil India Ltd. and Chairman of ONGC Videsh Ltd.) and will also have the director general Coast Guard or his nominee as member. It has been mandated to look into the circumstances leading to the accident and adequacy of the response, whether the offshore vessel *Samudra Suraksha* was sea worthy, and whether both the vessel and the platform had adequate safeguards and safety factors in accordance with international and Indian standards.

Among others, the panel has been asked to recommend action for improving the security of offshore oil and gas installations, including the coordination and inspection aspects of security arrangements.

ONGC has, meanwhile, secured its insurance claim of Rs. 762 crore from United India Insurance Company.

Court asks United India to pay cyclone claim to Usha International

The Delhi High Court has reportedly directed state-run United India Insurance Company Ltd. to pay about Rs. 1.38 lakh to Usha International Ltd. for the theft of insured goods from its godown in Cuttack in the aftermath of a super-cyclone in October 1999.

Justice Vikramjit Sen said the insurance company was asked to pay the sum with interest at the rate of 5 percent per annum from the date of the claim within four weeks. If the payments were not paid within the stipulated

period, the insurance company would be liable to pay the interest rate of 8 percent per annum together with the costs quantified at Rs. 10,000, the nine-page order said.

Usha International, a company engaged in manufacturing and marketing consumer merchandise such as electric fans, coolers, sewing machines, pump sets, diesel engines, piston rings, fuel injection sets and generators, had stored its goods in a store house at Cuttack. Despite insuring goods in its godowns all over

the country for Rs. 27 crore against cyclone and natural calamities and Rs. 20 crore for burglary and house breaking, by paying Rs. 1,44,398 between April 1, 1999 and March 31, 2000, the insurance company refused to pay the claim for the theft from its godown between November 1-2, 1999.

Filing a claim before the insurance company, Usha International said the employees of the company noticed that some miscreants had made forcible entry into the godown and managed to take away a large quantity of goods.

Court asks insurers to spell out terms of burglary claims clearly

The Delhi High Court has reportedly asked insurance firms to “redefine” the terms of policies they offer against the backdrop of the “stringent” definition of burglary that they chose to follow. Most insurance companies currently entertain a claim only when theft is preceded by “evidence of violence or force”, a distinction the court says consumers fail to understand at the time of taking policies.

Justice Vikramjit Sen directed: “... The terms of the policy as laid down by the insurance company should be suitably amended so as to make it more viable and facilitate the claimants to make their claim.”

Keeping in view the complex and tight definition of burglary, which was the basis of the petition before him, Justice Sen added: “The definition is so stringent in the present case that it gives rise to difficult situations for a common man to understand that in order to maintain their claim they will have to necessarily show evidence of violence or force... The common man understands that he has taken out the policy against the theft, he hardly understands whether it should be preceded by violence or force.”

The judge went on to say: “... We hope that the insurance companies will amend their policies... It should have a meaning which a common man can easily understand rather than become more technical so as to defeat the cause of the public at large.”

Justice Sen noted that in Black’s Law Dictionary, burglary is defined as breaking into another’s house with the intention of committing a felony. But he added that “... the modern statutory definitions of the crime are much less restrictive”, for they cover entry at all times at all kinds of structure. He said “force” should not be taken as an essential element, at least for purposes of an insurance policy.

Accepting the arguments of the petitioner, Usha International Ltd., against United India Insurance, the court directed the latter to pay Rs. 138,936 and interest at the rate of 5 percent per annum from the date when the claim was preferred

Katrina takes its toll on Indian insurers, too

Hurricane Katrina’s impact was not felt in the US alone. The Indian insurance market is also beginning to feel its ripples with global reinsurance premium hardening, say media reports. Indian insurers are finding it hard to negotiate lower reinsurance rates in the global market with reinsurers who have faced heavy losses due to the hurricane.

The hardening of rates was evident to Indian insurers while negotiating the deal for the first major policy involving a heavy reinsurance component - that of Indian Airlines. “Though the insurance premium for Indian Airlines is expected to be substantially lower than last year, we could have negotiated a better deal but for Hurricane Katrina. The reinsurance premium rates have gone up after the hurricane,” a top insurance company official was quoted as saying.

The Indian Airlines insurance deal was worked out in London last week among senior airline officials, Indian insurance companies and global reinsurers. The four state-owned insurers - Oriental Insurance, New India Assurance, United Indian Insurance and National Insurance - will be underwriting the cover.

Last year, too, Indian Airlines managed to wrangle a premium that was 18 percent lower, working out to a Rs. 107-crore premium (against Rs. 130 crore paid in the previous year.) The reduction this year is expected to be slightly higher in percentage terms. The insurance cover of Indian Airlines comes up for renewal in October each year. Indian Airlines has a mixed fleet of 62 aircraft that includes Airbus A-300, Airbus A-320, Boeing-737 and Dornier aircraft.

Insurance officials said the final premium amount is often lesser than the original quote made by the insurers, since hard bargaining with global reinsurance companies generally results in softening of reinsurance rates.

This gets reflected on the final premium payout to be made by the insured. They said that the exact premium amount would be known later, after negotiations are completed with reinsurers.

UK consumer body issues super-complaint against banks' policy

British banks reportedly face a government enquiry into the sale of 20 million payment protection insurance policies (PPI) after Citizens Advice issued a "super-complaint" against what it calls a "£5 billion "protection racket".

The charity presented its complaint to the Office of Fair Trading (OFT) after evidence from its bureau around the country found that PPI is "very expensive, mis-sold to people who cannot claim on it, and designed to exclude many of the most common situations that can lead to debt".

Citizens Advice is one of the few consumer bodies allowed to make formal super-complaints. The OFT is required to respond publicly within 90 days, which could trigger a formal enquiry and result in a cap on premiums and exclusions. The 20 million PPI policies in force are believed

to be hugely profitable for the banks. Last year, the *Guardian* revealed that Barclays made as much as 20 percent of all its profits from PPI, with £7 in every £10 spent on PPI going straight on to the bank's bottom line.

A report earlier this year from investment bank CSFB estimated that 14 percent of Lloyds TSB's profit comes from the sale of PPI policies, and named Barclays, Egg and Alliance & Leicester as relying on the policies for a major slice of their profits.

The policies are designed to cover credit payments in the event of illness or job loss. About 25 percent of credit card customers and half of loan customers buy payment protection from their bank. But many people who have been persuaded into taking out a PPI later find that they are unable to

make a claim. Department of Trade and Industry figures show only 4 percent of customers claim on it, of whom a quarter are turned down.

Citizens Advice said payment protection insurance is failing many of those who need it most. The insurance can add up to 25 percent to the cost of financing a loan, increasing the level of customers' debts instead of protecting them.

Research published last week into "best buy" loans and credit cards by moneyexpert.com found that none of the top five firms for cheapest loans of £5,000 and £10,000 over four years make the top five once PPI is included. Banks add as much as £900 in PPI costs on top of interest payments on a £5,000 loan over four years.

Premium rating errors pulling down revenues by \$16 billion: report

Premium rating errors continue to lower the overall profits of auto insurance companies, according to the annual Premium Rating Error report of Quality Planning Corporation (QPC), the Rating Integrity Solutions Company. QPC estimates that \$16 billion of premium revenues were foregone in 2004 due to inaccuracies in rating information - an increase of \$800 million over 2003 - say media reports. The amount represents about 9.8 percent of the \$163 billion revenue recognised by personal auto insurance premiums industry-wide. For the average auto insurer, each 1 percent of rating error losses translates into a 20 percent reduction in profitability, it has been reported.

QPC's Premium Rating Error report presents the results of premium audit reviews of more than 16 million private passenger auto policies from 18 major carriers in the US. The report highlights how different categories of rating errors contribute to the overall premium rating error, and distinguishes between vehicle rating errors (mileage, usage, type of vehicle and location) and driver rating errors (who actually drives the vehicle, driving experience and driving record).

In 2003, it was driver rating factors that contributed the most to rating error. In 2004, vehicle rating factors proved the most problematic for auto insurers, rising from \$6.1 billion to \$7 billion. The report indicates that flaws in rated commute distance, annual mileage, vehicle usage and rated territory were the primary contributors to the \$900 million increase. All of these rating errors offer the potential to be reduced if an auto insurer focuses underwriting activities on gathering, validating and maintaining accurate rating data.

Lloyd's looking for easier access to India

Insurance major Lloyd's of London has said that it is interested in entering the booming insurance and reinsurance sectors in India. For this, it plans to push the Indian Government for changes in the rules, according to newspaper reports.

Plans are afoot on relocating to India high-end back office operations from the UK, according to Lord Peter Levene, Chairman, Lloyd's. "We are in the insurance business for over 200 years, but we cannot operate directly in India as we are not a company but a market," Lord Levene said. Though globally it has the ability to accept around \$30 billion in insurance premiums, the India business is worth just around \$100 million, essentially through third-party insurance.

The market covers the toughest risks worldwide. Most of major insurers reinsure their risks with Lloyd's.

Insurers take sales increasingly online

While most insurance companies in the US metro area are using the Internet to provide quotes on premium rates, some of them – mainly healthcare insurers – are using the Web to sell directly to consumers and are seeing growth in business as a result, say media reports.

US-based Assurant Health has been selling short-term medical plans to individuals for seven years via the company's Web site. Of the product's total sales, half are occurring online, a report quotes spokesman Mr. Rob Guilbert as saying. Online sales in 2005 are already 50 percent more than 2004, he adds. The company is projecting a 60 percent increase by the end of 2005. Assurant's short-term medical plans provide health insurance for limited periods of time ranging from one month to one year. The policies are geared for customers who are between jobs or are recent college graduates. The company does not sell conventional insurance plans or health savings accounts online because of the underwriting required for those types of plans.

Blue Cross Blue Shield, another

US-based insurer, has sold health insurance online for individuals under the age of 65 and families since 2000. The company has sold about 800 policies per month since beginning sales via the Web.

Marketing online is found to be a more efficient way to sell directly to consumers, rather than having a call centre handle sales on phone lines. Often, the companies collect enough information about a person's health history via their Web sites that underwriters are able to review the information and contact individuals with quotes on premium rates. For customers, it offers an easy and convenient way to buy insurance without any pressure from a salesperson.

Online insurance sales are generally not too closely monitored by the states' insurance watchdogs. However, they do typically advise consumers to make sure that any insurance policy they buy online is from an insurance company licensed by the state to sell insurance, and that the insurer's policies are also state approved.

US insurers open Hurricane Insurance Information Center

In the aftermath of Hurricane Katrina, the US insurance industry has established the Hurricane Insurance Information Center (HIIC) in Jackson, Mississippi, according to reports. Additional centres will be opened in other Gulf Coast locations as conditions permit. The HIIC will act as a primary source of insurance information to the media and conduct an active consumer outreach programme in Louisiana, Mississippi and Alabama.

A web site, www.disasterinformation.org, will offer claim filing tips, provide general information on insurance coverages and refer people to insurers, government agencies and other sources of assistance. The insurance industry has created similar disaster insurance information offices following major catastrophes, including Hurricane Andrew in 1992, the Northridge Earthquake in 1994, the 9/11 terrorist attack in New York City and last year's Florida hurricanes. The disaster offices provided insurance information to thousands of displaced homeowners and businesses in restoring communities.

Companies and associations supporting the HIIC include Chubb Group of Insurance Companies, Lloyd's America, MetLife Auto & Home, Safeco and Swiss Re.

'Know thy neighbour but don't trust him'

There is little trust, leave alone love, across the fence. A recent study conducted by Lloyds TSB Insurance in the UK has revealed that while nine out of 10 people know their neighbours, less than one out of 10 trust them.

It has also revealed that around seven per cent admitted they did not even know who their neighbours were. While 38 per cent cited privacy as the reason for this, 14 per cent claimed it was because they were

too busy, and the same proportion put the lack of friendliness down to bad experiences. However, almost half of them claimed that they would like to befriend their neighbours if they get an opportunity.

One in three people said that they would like to get to know their neighbours better, and 49 per cent said they thought living in a close-knit community would make them feel safer and help reduce crime locally. A

third of people said they would consider an older family to be their ideal neighbours, while 29 per cent would like to live next door to an elderly couple. Unsurprisingly, students came out as the least preferred neighbours, with just one per cent of those questioned saying they would like to live next door to them.

The research was carried out on 1,329 people during August 2005.

FAIR Meet

The 19th Conference of the Federation of Afro-Asian Insurers and Reinsurers (FAIR) was held at Mumbai from September 19 to 21.



Mr. Albert J Nduna, President, FAIR, Mr. C. S. Rao, Chairman, IRDA, Mr. R. K. Joshi, Chairman-cum-managing Director, General Insurance Corporation of India and Mr. Izzat Abdel Bary, Secretary-General, FAIR lighting the lamp to inaugurate the 19th FAIR Conference, 2005

LUGI Meets

The Life Underwriters' Guild of India (LUGI) held its 3rd Annual Convention at Hyderabad from September 1 to 4.



L to R: Mr. Logan Naidu, Certified Financial Planner, South Africa, Mr. P. Srinivasan, President, LUGI, Mr. G. Jaishankar, Secretary General, LUGI, Mr. B. Mohan, Speaker on Financial Planning and other LUGI office bearers Mr. Brijbhooshan Chandhoke, Mr. J. Prabhu and Ms. Sharda Gopal at the inauguration of the conference.

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Even if we are willing to form a joint venture, the legislation does not allow us, as Lloyd's is a market. We hope the Indian Government recognises the Lloyd's structure and eventually allows us to enter the insurance sector...
We are interested in both direct insurance and reinsurance.

Lord Peter Levene, Chairman, Lloyd's of London

The function of underwriting and rating of insurance business should be independent of the business development function and not be made subservient to it.

Mr. C. S. Rao, Chairman, IRDA outlining a Road Map for a Tariff free Regime in Non-Life insurance in India.

Meteorological research estimates that more than 80 per cent of the turnover and profitability of all economic activities are dependent on the weather.

Munich Re report on Innovation and Insurance Trends

You cannot possibly eliminate the risk, (but) the whole industry is working hard to minimise instances of this. You are not always going to have absolutely accurate information on the day you are striking the unit price.

Mr. Steve Somogyi, Member, Australian Prudential Regulation Authority (APRA) on instances of mispricing which have totalled more than Aus \$240 million in recent years, mostly on prices of units.

We expect firms to follow the principle that a firm must pay due regard to the interests of its customers and treat them fairly. Most firms aim to do this – after all, it would not make commercial sense to set out to treat your customers unfairly – but we still see instances where this is not the case.

Mr. Clive Briault, Managing Director, Retail Markets, Financial Services Authority (FSA), UK

The cost of capital plays a key role in defining the profitability of insurers, and underwriting profitability is an important driver of investor confidence, together with profitable top line growth and scale of operations.

Swiss Re's latest sigma report.

Events

10 - 12 October, 2005

Venue: Pune
Workshop on Micro Insurance by
National Insurance Academy, Pune

23 - 26 October, 2005

Venue: Taipei
22nd Pacific Insurance Conference by
Asia Insurance Review (AIR)

7 - 8 November, 2005

Venue: Shanghai
6th China Rendezvous by AIR

16 - 18 November, 2005

Venue: Mumbai
World Conference on Disaster Reduction -
Focus on Corporate Sector Role &
Responsibility by NIA, Pune

18 - 19 November, 2005

Venue: Pune
2nd Global Symposium on Pensions by NIA, Pune

21-22 November, 2005

Venue: Pune
Silver Jubilee Seminar on Business Continuity Management
by NIA, Pune

28 - 29 November, 2005

Venue: Hong Kong
2nd Conference On Pensions & Retirement Planning by AIR

28 - 29 November, 2005

Venue: Dubai
2nd Annual Gulf Insurance Forum by AIR