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Journal

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Inside

ISSUE FOCUS

From the Publisher

One of the primary objectives of allowing the entry of private sector into insurance was facilitate greater spread of insurance coverage. While the expansion of insurance coverage is the primary goal, the policy makers are also aware that growth alone would not, ipso facto, ensure equity. The trickle down effect had not worked effectively in the rest of the economy and there is no reason to believe that it would work in the case of insurance. The Insurance Act and the Regulations made there-under, therefore, prescribe that a certain percentage of the policies should cover exclusively the weaker sections of the population.

The draft regulations on micro insurance prepared by the IRDA provides the facilitative mechanism to achieve the social objectives underlying the regulations. These regulations draw heavily upon the micro credit mechanisms that already exist in the country. The Authority is also aware of the informal systems of micro insurance that have gained ground in various parts of the country and the Regulations give them not only legal sanction but also make the practioners accountable. This month's journal covers extensively the issues relating to micro insurance. The draft regulations have been on our website for a long time and we received suggestions from both national and international agencies. We have benefited from this consultative process and modified the regulations wherever necessary.

In this issue we have also incorporated the annual business figures for the year 2004-05. We have witnessed robust growth in both life and general insurance. A significant feature is the continued strong performance by private players who have steadily increased their market share to a little over one fifth of the first year premium in life and overall premium in the case of general insurance.

We propose to examine, in the next issue, how to simplify the language used in insurance contracts so that they are easily understood by the insured. The language of the insurance contract has traditionally been unfathomable except to a privileged few! The Plain Language movement, aimed at translating legalese into familiar words to empower the common man with knowledge of his rights and duties is most suitable to the insurance industry. It has created ripples abroad and is one of the most consumer friendly practices among insurance companies. We will take a look at what has been achieved internationally and what could be done to effect the transition to plain English in India.

C.S. Rao

C.S.RAO

Change...

A good measure of a human being is how he treats his subordinates. So it is with a society. Taking care of those who, by their circumstances, are unable to do so themselves, has been the aspiration of almost all developed societies and economies.

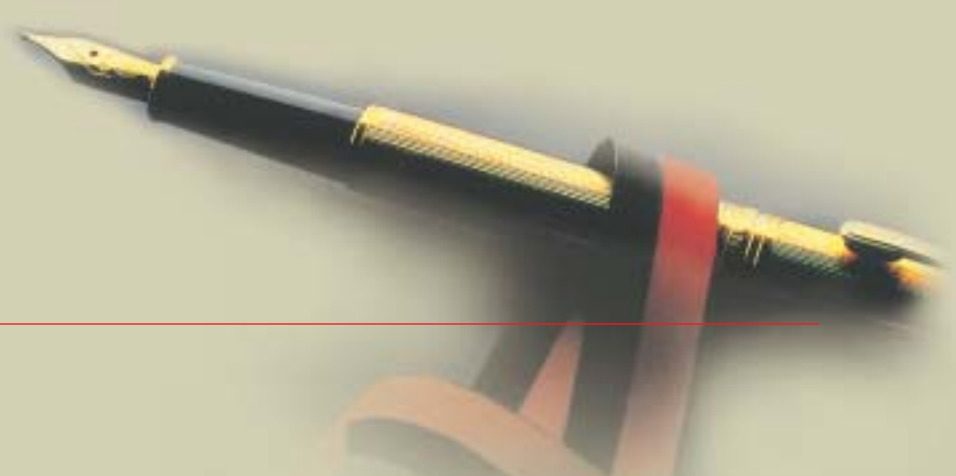
It is not only support for subsistence but assistance to step up in life that concepts like micro finance and micro insurance envisage. One by providing credit for income generating activities and the other, by protecting the precious little increments to assets, not to speak of health and life – the very means of accumulating those assets.

In this issue we consider micro insurance and how it can become a reality. Mr. Arup Chatterjee, Deputy Director of IRDA, now on deputation to the International Association of Insurance Supervisors (IAIS) writes on the challenges of micro insurance and how to overcome them while Ms. K. G. P. L. Rama Devi, Assistant Director at IRDA explores ways and means to spread micro insurance while avoiding the downside.

In this issue we restart the section End User, for which we are constantly on the look out for good articles, with a new writer. Mr. Gnanasundaram Krishnamurthy, retired Chairman, LIC who was the Insurance Ombudsman for Maharashtra and Goa will write a series from his experiences in both capacities.

We have for you your favourite section in full splendour this month – statistics for the year 2004-05 with business class wise breakups. The pattern of sales across different types of products – whether it is Motor, Fire and Health in non-life insurance, or unit linked/traditional, individual/group or single premium/ non-single premium in life insurance – throws up trends worthy of note.

The next issue of the Journal will be about the use of plain language by the industry to communicate with its customers. Communications, as they say, is the core of any good relationship and we will see just how important it is for an industry that has long term relationships with its customers and one that is expected to stay with them in good times and bad!



Clear and Simple

K. Nitya Kalyani

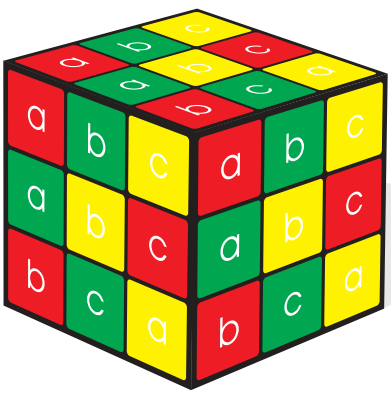
The writing and setting out of essential information in a way that gives a cooperative, motivated person a good chance of understanding it at first reading, and in the same sense that the writer meant it to be understood"

-Martin Cutts, Oxford Guide to Plain English

Simple enough, in other words. But with most things, people make them more complicated than necessary, sometimes defeating the very purpose.

Insurance being an intangible product, consumers are more apt to misunderstand, or understand partially, the scope and nature of the cover they are buying. The dense language of legal contracts, which is what an insurance policy is, is hardly user friendly or conducive to quick and clear comprehension.

The objective of an industry has to be to provide a lasting value proposition to its customers. Its image as a reliable and longlasting partner is wrought through various efforts on the part of the companies, of which clear and appropriate communication is both a subtle and visible factor. Visible for obvious reasons, and subtle because when language and communication work as they should, they turn 'invisible.' Their effectiveness draws attention away from their efficiency.



Yet, consumers the world around are burdened with unclear and inefficient communication leading to a situation where they either lose out as consumers or are left negotiating the mazes trying to obtain justice and fairplay.

> Insurance as a product itself demands a vast communications initiative which has to be simple and clear to be effective.

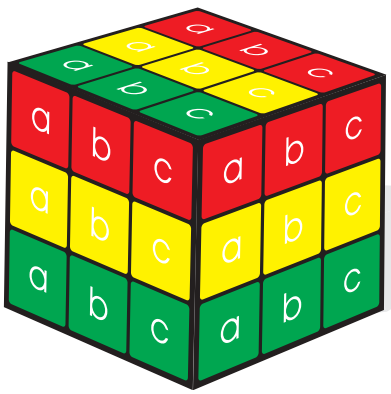
It's not surprising that one of the most sustained consumer movements is based on simplifying communications language and converting clear language into a desirable product attribute. In the insurance industry this has led to the use, and proclamation of the use, of simple language in policy wordings a selling point!

That it has not yet become a hygiene factor is sad. Very sad. For documentation and communication can certainly be templatised in business.

Clear writing is not that difficult. Once the problem is defined and so are the objectives, drafting documentation wordings and standardised business correspondence in language that follows the basic tenets of good communication – brevity and clarity mainly – is not all that difficult. And once the system is in place it should be pretty easy to follow it too.

In the next issue of **IRDA Journal** we will dwell on the entire issue of plain language in the insurance industry and see where we stand in India in its adaptation. The huge level of awareness that still needs to be created about insurance as a product itself demands a vast communications initiative which has to be simple and clear to be effective.

Even more interesting would be to explore the potential of communication in the regional languages, taking the product truly close to the consumer. It is when the industry become comfortable taking its communications to this level that it will have a glimpse of the potential that it can unlock across the breadth of the Country.



BROKER LICENCE SUSPENDED

IRDA has suspended the licence of New Delhi-based broking company Just Insure Brokers Ltd. on the grounds that the company does not have a Prinicpal Officer with the required educational qualifiications. The company had initially responded that its then Prinicipal Officer had suddenly resigned, and that he was under probe for alleged malpractices. However, the company's Chairman later did not appear before IRDA as had been advised. Following this, the licence was suspended. The letter issued by IRDA reads as follows:

Re : Suspension of direct insurance brokers licence

Whereas your company M/s Just Insure Brokers Ltd. is registered with IRDA as Insurance Broker (hereinafter referred to as 'the broker') having registration code No. DB 095/03. Whereas the IRDA (Insurance Brokers) Regulations, 2002 (hereinafter referred to as 'the regulations') mandates that every insurance broker shall have a Principal Officer possessing the prescribed educational qualification, who must have undergone and passed the prescribed examination.

Whereas on getting information about the above broking company working without a trained Principal Officer the Authority issued a notice dated the 2nd December 2004 pointing out the said violation and also calling upon you to show cause why the Broking licence granted to them should not be suspended for violating Regulations 9(2)(F) , Regulation 34(1)(k)&(m) of IRDA (Insurance Brokers) Regulations, 2002.

Whereas when the duly addressed notices to your company returned undelivered with the remarks that the address of your company had changed the Authority had to publish last and final notice on its website vide Notice No. IRDA/NOT/BRO/063/Jan-05 dated the 10th January 2005 pointing out the violation of law and asking your company to show cause why the broker licence granted to you should not be suspended/cancelled for the violations mentioned therein.

Whereas you have vide letter dated the 14th January 2005 paid the annual fees and apologised for the delay. Further you had in the reply attempted to explain the non-intimation of change of address and contended that the then Principal Officer Mr. Vohra had not notified you about his intentions to discontinue with your company and that he is under investigation for irregularities and mismanagement.

Whereas a letter dated 25th April 2005 was also issued to Dr. Rajiv Sharma, Chairman of the above broking company advising him to appear personally before the Authority in order to give him a further opportunity of being heard as specified in Reg. 34 of the said regulations with regard to the above mentioned violation.

Whereas Mr. Rajiv Sharma vide his reply dated the 11th May, 2005 has chosen not to avail the opportunity of personal hearing and expressed his inability to leave Delhi till 20th June 05 and also admitted the fact of not having appointed a duly qualified Principal Officer for the above broking company.

Whereas your company has been virtually working without a Principal Officer since 1st November 2004 till date and there is failure to comply with the said regulations and the Circular No. IRDA/BRO/36/AUG-04 dated the 18.08.04 in spite of elapse of considerable time in this regard.

In view of the above and on examining the facts and material on record, the Authority is satisfied that this is a fit case to impose the penalty of suspension of licence of the broker. Therefore, in exercise of the powers conferred upon the Authority by Regulation 34 of IRDA (Insurance Brokers) Regulations, 2002, the Authority hereby temporarily suspends the Licence No.DB-095/03 granted to your company with immediate effect till a duly qualified Principal Officer is appointed as mandated by the Regulations and the Circular.

You are further directed to acknowledge receipt of this notice and confirm suspension of all insurance broking activities with immediate effect. They will not be entitled to payment of any remuneration for the insurance broking activities carried out w.e.f. 1st June 2005 which please note.

Sd/- Mathew Verghese - Member (Non-Life)

BROKER SURRENDERS LICENCE

The Kolkata based direct insurance broker, Inspire Ensurance Broking Solutions has sought to surrender its licence, and IRDA is taking steps to ensure that all its customers' interests are taken care of. The circular issued by IRDA regarding this matter reads thus:

20th June, 2005
IRDA/DB/096/03

This is to inform all concerned, that M/s. Inspire Ensurance Broking Solutions Pvt. Ltd., a Direct Insurance Broker having Insurance Broking License No. 201, Code No. DB096-03 presently having Regd. Office at Commerce House, 5th Floor, 2 A, Ganesh Chandra Avenue, Kolkatta have voluntarily approached this Authority to surrender the direct insurance broking license granted to them.

The broking company has informed the Authority about stopping of all fresh insurance business w.e.f 30th October 2004. The Authority is initiating steps to ensure that the policyholders who have placed their insurance business through them do not suffer in case their request for surrender is accepted by it. The broking company has undertaken to retain their technical staff till the policy period of all policies sold by them expires.

This notice is being issued as an opportunity to all concerned to express objections/claims if any, with regard to the surrender of broking license by the above mentioned company. Any person/body having any claim/objection regarding the above may approach the undersigned at the below mentioned address latest within 30 days from the date of publication of this notice.

Sd/- Mathew Verghese - Member (Non-Life)

Committee to study Law Commission report gets deadline extension

The IRDA formed committee to study certain issues put forth by the Law Commission was to submit its findings by April 30, 2005. However, the committee requested an extension of the deadline to June 30, and later July 31, 2005. IRDA has consented to extend the deadline to July 31, 2005. A circular in this regard dated June 8, 2005 runs thus:

8th June, 2005

Sub: Committee to study the Report of the Law Commission and make recommendations – regarding

In the reference cited above a committee was constituted to examine some of the issues which, according to the Law Commission, required detailed examination by experts before any decision can be taken about the need for changes in the provision of the Act. This committee was also requested to examine any other areas where legal provisions required amendments in the light of the developments that have taken place so far. The committee was requested to furnish its report by 30th April 2005. The committee submitted its first report on 28th April 2005 and sought time till 30th June 2005 for submission of its final report. It has now indicated that time till 31st July 2005 would be required to submit the final report.

The Authority has considered the matter and decided to extend the term of the committee up to 31st July 2005.

Sd/- C. S. Rao - Chairman

Report Card:LIFE

May growth at 16%

The life insurance industry underwrote a premium of Rs.1,41,749.50 lakh during the month of May, 2005, taking the cumulative premium underwritten for the first two months of the FY 2005-06 to Rs.2,67,776.01 lakh.

The total Individual and Group premium underwritten were Rs.2,18,668.84 lakh (81.66 per cent) and Rs.49,107.18 lakh (18.34 per cent) respectively as against Rs.1,47,501.49 lakh (64 per cent) and Rs.82,950.58 lakh (36 per cent) underwritten in April-May, 2004. The premium underwritten by the industry upto May, 2005, towards individual single and non-single policies stood at Rs.70,990.81 lakh and Rs.1,47,678.03 lakh respectively accounting for 2,12,088 and 19,51,216 policies.

The group single and non-single premium accounted for Rs.43,030.94 lakh and Rs.6,076.23 lakh. The number of lives covered by the industry under the various group schemes was 8,58,296. LIC covered 5,17,919 lives under the group schemes accounting for 60.34 per cent of the market, followed by Tata AIG with 1,03,378 lives (12.04 per cent) and SBILife with 72,232 lives (8.42 per cent).

LIC underwrote premium of Rs.2,02,726.72 lakh during the period i.e., a market share of 75.71 per cent, followed by ICICI Prudential and Bajaj Allianz with premium underwritten (market share) of Rs.20,552.70 lakh (7.68 per cent) and Rs.9,714.51 lakh (3.63 per cent) respectively. The new players underwrote first year premium of Rs.65,049.29 lakh as against Rs.38,546.12 lakh in April- May, 2004.

Life, Annuity, Pension and Health contributed Rs.1,71,679.35 lakh (64.21 per cent), Rs.6,892.41 lakh (2.58 per cent), Rs.88,714.15 lakh (33.18 per cent) and Rs.67.19 lakh (0.025 per cent) respectively to the total premium. 61.66 per cent of the business was underwritten in the non-linked category, and 38.34 per cent in the linked category, i.e, Rs.1,64,852.44 lakh and Rs.1,02,500.66 lakh respectively.

First Year Premium Underwritten by Life Insurers for and upto May, 2005

(Rs lakh)

Sl No.	Insurer	Premium 2005-06		Premium 2004-05	Growth	Market share	No. of Policies / Schemes 2005-06 (Premium)		No. of Policies / Schemes 2004-05	Growth	Market share (Policies)	No. of lives covered under Group Schemes 2005-06		No. of lives covered under Group Schemes 2004-05	Growth	Market share (lives covered)
		May	Upto May	Upto May	Upto May	Upto May	May	Upto May	Upto May	Upto May	Upto May	May	Upto May	Upto May	Upto May	Upto May
1	Bajaj Allianz	6,797.09	9,714.51	3,722.72	160.95	3.63	24,988	39,106	18,253	114.24	1.81	1,153	5,472	1,751	212.51	0.64
	Individual Single Premium	3,005.01	4,203.87	1,064.94			3,103	5,137	1,494							
	Individual Non-Single Premium	3,412.42	4,983.89	2,627.49			21,873	33,949	16,751							
	Group Single Premium															
	Group Non-Single Premium	379.66	526.75	30.29			12	20	8			1,153	5,472	1,751		
2	ING Vysya	948.74	1,146.82	536.94	113.58	0.43	4,979	5,697	8,710	-34.59	0.26	1,912	2,221	3,626	-38.75	0.26
	Individual Single Premium	1.65	1.96	31.39			243	289	4,621							
	Individual Non-Single Premium	845.61	1,032.57	481.20			4,726	5,395	4,087							
	Group Single Premium	85.40	92.54	11.93							234	279	69			
	Group Non-Single Premium	16.08	19.74	12.42			10	13	2			1,678	1,942	3,557		
3	AMP Sanmar	631.83	1,479.48	547.28	170.34	0.55	3,283	7,278	4,478	62.53	0.34	5,989	22,110	5,308	316.54	2.58
	Individual Single Premium	425.70	971.28	253.13			705	1,601	536							
	Individual Non-Single Premium	179.88	389.32	283.19			2,576	5,669	3,939							
	Group Single Premium	8.01	29.69													
	Group Non-Single Premium	18.25	89.20	10.95			2	8	3			5,989	22,110	5,308		
4	SBI Life	3,284.30	4,600.04	2,747.39	67.43	1.72	18,911	21,458	10,639	101.69	0.99	55,704	72,232	35,436	103.84	8.42
	Individual Single Premium	487.96	589.22	781.64			853	933	389							
	Individual Non-Single Premium	1,121.76	1,411.58	646.76			17,872	20,295	10,142							
	Group Single Premium	1,250.47	2,156.67	1,173.69			1	1	1			8,779	16,795	11,927		
	Group Non-Single Premium	424.11	442.57	145.31			185	229	107			46,925	55,437	23,509		

5	Tata AIG	2,605.69	5,351.45	3,497.54	53.01	2.00	18,365	41,062	33,149	23.87	1.90	23,195	1,03,378	41,005	152.11	12.04
	Individual Single Premium															
	Individual Non-Single Premium	2,459.70	5,032.11	2,706.03			18,342	41,012	33,128							
	Group Single Premium	85.89	148.68	100.47								11,341	18,882	12,717		
	Group Non-Single Premium	60.10	170.66	691.04			23	50	21			11,854	84,496	28,288		
6	HDFC Standard	4,753.82	7,790.33	3,300.66	136.02	2.91	15,757	28,238	17,019	65.92	1.30	12,969	24,056	18,277	31.62	2.80
	Individual Single Premium	725.30	1,277.93	1,021.50			3,358	5,792	1,825							
	Individual Non-Single Premium	3,575.96	5,460.74	2,154.37			12,388	22,417	15,165							
	Group Single Premium	294.71	328.51				8	21				12,410	17,898			
	Group Non-Single Premium	157.85	723.15	124.79			3	8	29			559	6,158	18,277		
7	ICICI Prudential	13,384.45	20,552.70	13,625.40	50.84	7.68	33,226	70,733	64,181	10.21	3.27	28,253	34,569	5,068	582.10	4.03
	Individual Single Premium	528.70	923.69	2,392.15			382	656	1,677							
	Individual Non-Single Premium	9,635.65	15,805.75	8,838.52			32,830	70,024	62,480							
	Group Single Premium	87.64	103.01	5.79			8	17	3			28,025	32,704	622		
	Group Non-Single Premium	3,132.46	3,720.26	2,388.94			6	36	21			228	1,865	4,446		
8	Birla Sunlife	2,899.58	4,712.44	5,981.81	-21.22	1.76	9,426	16,741	14,416	16.13	0.77	2,981	3,873	2,951	31.24	0.45
	Individual Single Premium	68.26	190.49	191.40			1,602	3,576	2,585							
	Individual Non-Single Premium	2,786.01	4,361.20	3,862.84			7,824	13,159	11,821							
	Group Single Premium	14.98	65.90	65.71								312	669	548		
	Group Non-Single Premium	30.33	94.85	1,861.85				6	10			2,669	3,204	2,403		
9	Aviva	1,888.84	2,977.88	1,791.37	66.24	1.11	6,906	10,880	9,916	9.72	0.50	18,885	24,930	13,580	83.58	2.90
	Individual Single Premium	-51.03	-38.61	90.56			113	281	49							
	Individual Non-Single Premium	1,907.18	2,955.51	1,666.55			6,792	10,598	9,860							
	Group Single Premium	12.45	22.06									82	172	0		
	Group Non-Single Premium	20.23	38.92	34.26			1	1	7			18,803	24,758	13,580		
10	Kotak Mahindra Old Mutual	1,468.28	2,110.03	939.09	124.69	0.79	5,312	8,422	4,426	90.28	0.39	4,867	10,220	21,592	-52.67	1.19
	Individual Single Premium	-94.77	-48.80	75.70			171	263	40							
	Individual Non-Single Premium	1,497.77	2,043.04	477.13			5,136	8,149	4,383							
	Group Single Premium	5.99	5.99									371	371	0		
	Group Non-Single Premium	59.29	109.80	386.27			5	10	3			4,496	9,849	21,592		
11	Max New York	1,961.95	3,563.77	1,460.28	144.05	1.33	18,954	38,314	14,059	172.52	1.77	1,082	5,210	24,197	-78.47	0.61
	Individual Single Premium	13.39	27.31	37.21			19	35	23							
	Individual Non-Single Premium	1,947.10	3,485.80	1,387.24			18,934	38,270	14,020							
	Group Single Premium															
	Group Non-Single Premium	1.46	50.66	35.83			1	9	16			1,082	5,210	24,197		
12	Met Life	660.91	1,008.02	395.65	154.78	0.38	5,676	7,705	2,466	212.45	0.36	19,447	32,106	15,434	108.02	3.74
	Individual Single Premium	36.85	53.69	10.31			76	99	33							
	Individual Non-Single Premium	635.53	864.65	313.15			5,584	7,574	2,418							
	Group Single Premium															
	Group Non-Single Premium	-11.47	89.68	72.19			16	32	15			19,447	32,106	15,434		
13	Sahara Life	34.77	41.83			0.02	1,866	2,183			0.10					
	Individual Single Premium															
	Individual Non-Single Premium	34.77	41.83				1,866	2,183								
	Group Single Premium															
	Group Non-Single Premium															
14	LIC	1,00,429.25	2,02,726.72	1,91,905.96	5.64	75.71	11,78,458	18,67,513	20,30,354	-8.02	86.25	3,67,222	5,17,919	4,87,722	6.19	60.34
	Individual Single Premium	28,758.82	62,838.78	12,413.87			83,325	1,93,426	28,604							
	Individual Non-Single Premium	60,233.46	99,810.05	1,03,693.23			10,94,184	16,72,522	20,00,166							
	Group Single Premium	11,436.97	40,077.89	75,798.86			949	1,565	1,584			3,67,222	5,17,919	4,87,722		
	Group Non-Single Premium															
	Total	1,41,749.50	2,67,776.01	2,30,452.08	16.20	100.00	13,46,107	21,65,330	22,32,066	-2.99	100.00	5,43,659	8,58,296	6,75,947	26.98	100.00

FY 2004-05: LIFE Single Premium Policies Dominate

—Account for over 60% of 2004-05 new business growth

G. V. Rao

New business in life insurance in India in 2004-05 has had an impressive growth rate of 35.7 per cent. The industry has recorded a new business premium level of Rs. 25,343 crore with an accretion of Rs. 6,674 crore over last year. LIC, the most famous name of all the insurers in India, has contributed Rs. 3,546 crore (21.8 per cent growth rate) to it, while the 13 new players have made a highly significant contribution of Rs. 3,128 crore (128.7 per cent growth rate).

This article will examine and analyse the growth trends in each life segment, the particular strategies followed by LIC and the other new players.

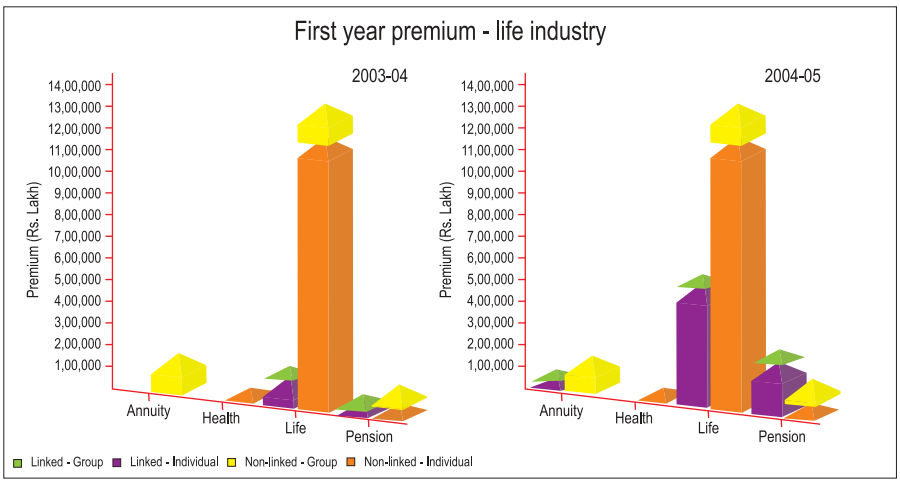
Of the total increase of Rs. 6,674 crore, the individual single premium segment of the market has risen by Rs. 4,219 crore and the individual non-single premium segment by Rs. 2.098 crore, together Rs. 6,317 crore, making it obvious that the growth in life insurance is still driven by individuals, and that the single premium segment is the most popular of them all accounting for 95 per cent of the growth of the industry.

While the premium in the individual single premium segment grew by 207 per cent the sum assured grew by Rs. 3,892 crores or 87 per cent. In the individual non-single premium segment, premium growth was 16 per cent while the sum assured actually dropped by Rs. 1,059 crore or 4.5 per cent.

The individual life segment alone, as opposed to group life segment, amounted to about 82.7 per cent of the total new business in 2004-05 as against 78.4 per cent for the last year. Corporate driven insurances, represented by the Group segment, is yet to take off in a big way.

> The individual life segment alone, as opposed to group life segment, amounted to about 82.7 per cent of the total new business in 2004- 05.

LIC has dominated the accretion in individual single premium segment with a massive increase of about Rs. 3,491 crore and the new players have followed it up with an increase of about Rs. 727 crore. In the segment of individual non-single premium, the new players have dominated with an increase of Rs. 2,102 crore, while LIC dropped by Rs. four crore.



Market shares

These respective market contributions have also changed the market shares of LIC and the others. LIC that had 87 per cent share of the growth of new business last year is now down to 78 per cent in 2004-05. Who among the new players are stealing the public delight for competition for their business?

ICICI Prudential, Bajaj Allianz, Birla SunLife, HDFC StandardLife and SBILife are the top five life insurers in the private sector with new business in excess of Rs. 450 crore each. ICICI leads with a new business premium of Rs. 1,584 crore and with a market share of 6.2 per cent (four per cent last year) of the total new business. Bajaj is a distant second with Rs. 860 crore and with a market share of 3.4 per cent (one per cent last year). HDFC have raised theirs from 1.1 per cent to 1.9 per cent.

What is the contribution of unit-linked life products?

The analysis of unit-linked products and their sales realisation will be of interest, given the on-going debate on such products as 'real' life insurance covers and the extent to which they are of pure investment potential, the latter risk being passed on to the insured.

Such unit-linked products are sold both under the individual single premium and non-single premium segments. Under the individual single premium segment, the total new business done in 2004-05 is Rs. 5,904 crore while linked policy sales alone is Rs. 4,940 crore and non-linked Rs. 964 crore. The number of policies sold in the segment is 1.86 lakhs with linked policies numbering 1.51 lakh.

Coming to the individual non-single premium segment, the total new

premium completed is Rs. 15,034 crore of which linked policies is Rs. 3,041 crore. The individual single premium segment seems to be the favorite ground for unit-linked sales of insurance covers.

Summarising, of the total premium of Rs. 25,343 crore life new premium, the individual segment contributed Rs. 20,933 crore, the balance coming from group insurance covers. Within the segment, single-premium policies contributed Rs. 5,904 crore and non-single premium policies Rs. 15,033 crore. Of individual single premium policies unit linked policies contributed Rs. 4,940 crore while it constituted Rs. 3,041 crore of the non-single segment. In all, linked policies contributed Rs. 7,981 crore (31 per cent) to the total accretion in life new business.

The number of polices sold in the individual single premium segment was 18 lakhs and the premium collected is Rs. 5,904 crore at an average of Rs. 32, 794 per policy. In the individual non-single segment the premium collected was Rs. 15,033 crore on policies numbering 2.43 crore with an average per policy of Rs. 6,200. Clearly life insurers do love the single premium segment and the linked policy!

LIC and individual single premiums

LIC' s total accretion is Rs. 3,546 crore (21.8 per cent.) It has now targeted individual single premiums for its focused growth strategy. This segment alone grew by Rs. 3,492 crore out of LIC's total accretion of Rs. 3, 546 crore for 2004-05. The individual single premium last year was 8.6 per cent of the total new business; in 2004-05 it forms 24.7 per cent.

There is even a slight drop of Rs. four crore in the quantum of the huge individual non-single premiums that formed 73.6 per cent last year, which has now shrunk to 56.6 per cent in 2004-05. The strategic change in their growth to individual single premium could not be more explicit and dramatic.

The individual single and individual non-single premiums together formed 81.2 per cent of the new business in 2004-05 against 82.2 per cent last year. Clearly, LIC is thus doing a marvelous piece of work in bringing individuals in to the fold of insurance; and in 2004-05 they have pursued individual non-single premiums more vigorously than ever before.

New Players

The new players have collected a total of new premium of Rs. 5, 557 crore in 2004-05 up from Rs. 2,429 crore, with an accretion of Rs. 3,128 crore (128 per cent growth). Nearly 70 per cent of the new premiums collected are from individual non-single premium segment and 18 per cent from individual single premium segment. LIC in contrast has 57 per cent of individual non-single and 25 per cent individual single premium segments in its total new business portfolio.

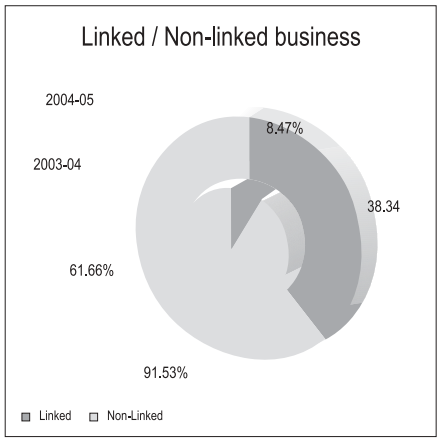
> Linked policies contributed Rs. 7,981 crore (31 per cent) to the total accretion in life new business.

The growth strategies of the two seem to diverge with the new players pitching in for individual non-single premium segment in a big way to raise their premium levels. Among the new players ICICI, Birla and Bajaj are the major players in this effort with more than 50 per cent of the increase in this segment coming from them.

AMP Sanmar and MetLife, not having crossed the Rs. 100 crore mark yet, are in the lower brackets of the new players.

End piece

In the individual single premium segment the insureds have shown a marked preference for LIC. In the individual non-single premium segment the new players are finding opportunities for themselves as LIC has diverted its attention from it to drive for premium growth in the individual single premium segment.



As far as the group premium segment is concerned, SBI Life dominates in the group single premium segment possibly through its housing loans, while HDFC, Birla, Tata and ICICI dominate the field in the group non-single premium group segment through cultivating their corporate accounts.

The new players and the LIC have drawn their respective strategies and it is interesting to wait and watch how these will translate in the new business premium rises in 2005-06. Will the current fiscal be as good, or even more spectacular, than the preceding one? With the stock market booming and with more disposable incomes in the pockets of the young and employed, life insurance is on the upswing and one can pitch for a 40 per cent growth in 2005-06 with the right strategies. LIC with 78 per cent of the market is the engine for individual single premium segment.

The author is retired CMD, The Oriental Insurance Company.

INDIVIDUAL NEW BUSINESS — SINGLE PREMIUM (INCLUDING RURAL & SOCIAL) 2004-2005 (PROVISIONAL)

(Rs lakh)

Sl No.	PARTICULARS	PREMIUM		POLICIES		SUM ASSURED		AVERAGE FOR 2004-05	
		2003-04	2004-05	2003-04	2004-05	2003-04	2004-05	Premium per policy	Average sum assured
	Non linked*								
1	Life								
	with profit	32,050.24	39,698.60	56,070	44,379	40,861.80	53,424.10	0.89	1.20
	without profit	62,016.10	38,051.99	1,75,131	1,67,813	1,00,967.36	1,81,062.04	0.23	1.08
2	General Annuity								
	with profit	22.07	27.00	18	13	38.60	44.44	2.08	3.42
	without profit	18.29	26.74	2	5			5.35	
3	Pension								
	with profit	10,505.44	12,932.19	65,168	75,420	712.52	469.46	0.17	
	without profit	13,928.71	5,655.51	24,879	2,606	1.00	39.20	2.17	
4	Health								
	with profit								
	without profit								
A.	Sub total	1,18,540.86	96,392.02	3,21,268	2,90,236	1,42,581.27	2,35,039.24		
	Linked*								
1	Life								
	with profit	228.01	70.97	196	67	225.74	72.37	1.06	1.08
	without profit	46,368.76	2,86,143.04	96,555	5,71,744	63,032.32	3,58,787.35	0.50	0.63
2	General Annuity								
	with profit								
	without profit								
3	Pension								
	with profit								
	without profit	3,310.46	2,07,806.31	2,516	9,44,630	537.97	1,072.87	0.22	
4	Health								
	with profit								
	without profit								
B.	Sub total	49,907.22	4,94,020.31	99,267	15,16,441	63,796.03	3,59,932.59		
C.	Total (A + B)	1,68,448.08	5,90,412.33	4,20,535	18,55,947	2,06,377.30	5,94,971.83		
	Riders:								
	Non linked								
1	Health#	13.50	14.19	78	69	222.70	235.65	0.21	
2	Accident##	19.91	26.31	1183	2,156	1,664.73	2,107.95	0.01	
3	Term	1.24	5.08	41	158	36.79	136.95	0.03	
4	Others								
D.	Sub total	34.65	45.57	1302	2,383	1,924.22	2,480.55	0.02	
	Linked								
1	Health#	3.40	1.95	21	22	36.55	30.80	0.09	
2	Accident##	1.48	1.24	54	56	77.43	150.81	0.02	
3	Term	1.47	0.04	11	1	20.45	1.00	0.04	
4	Others								
E.	Sub total	6.35	3.22	86	79	134.43	182.61	0.04	
F.	Total (D + E)	41.00	48.80	1388	2,462	2,058.65	2,663.16	0.02	
G.	**Grand Total (C + F)	1,68,489.08	5,90,461.13	4,20,535	18,06,677	2,08,435.95		5,97,634.99	

* Excluding rider figures.

** for policies Grand Total is C.

All riders related to critical illness benefit, hospitalisation benefit and medical treatment.

Disability related riders.

The premium is actual amount received and not annualised premium.

INDIVIDUAL NEW BUSINESS — NON SINGLE PREMIUM (INCLUDING RURAL & SOCIAL) 2004-2005 (PROVISIONAL)

(Rs lakh)

Sl No.	PARTICULARS	PREMIUM		POLICIES		SUM ASSURED		AVERAGE FOR 2004-05	
		2003-04	2004-05	2003-04	2004-05	2003-04	2004-05	Premium per policy	Average sum assured
	Non linked*								
1	Life								
	with profit	10,70,899.85	10,68,076.90	2,54,90,262	2,11,54,096	1,77,80,153.19	1,69,48,055.39	0.05	0.80
	without profit	72,219.50	74,055.22	16,13,963	14,04,808	32,96,706.26	27,12,262.89	0.05	1.93
2	General Annuity								
	with profit	348.81	438.68	3,395	4,859	7,141.51	9,654.43	0.09	1.99
	without profit								
3	Pension								
	with profit	31,822.65	44,822.53	3,02,552	4,11,000	99,804.98	85,246.51	0.11	
	without profit								
4	Health								
	with profit	2,096.72	11,579.47	49,235	2,31,847	61,038.92	2,73,900.68	0.05	1.18
	without profit	11,241.90	318.86	1,33,194	16,093	2,86,319.60	24,605.73	0.02	1.53
A.	Sub total	11,88,629.43	11,99,291.66	2,75,92,601	2,32,22,703	2,15,31,164.47	2,00,53,725.62		
	Linked*								
1	Life								
	with profit	2,449.28	769.57	19,267	2,604	35,312.72	6,950.72	0.30	2.67
	without profit	77,963.65	2,59,984.13	3,64,183	8,01,903	8,14,845.56	21,45,406.37	0.32	2.68
2	General Annuity								
	with profit								
	without profit		22,096.10		2,09,830		44,585.93	0.11	0.21
3	Pension								
	with profit	296.74	235.25	2,318	783			0.30	
	without profit	23,953.72	21,030.93	2,10,651	1,43,289	45,498.07	17,195.34	0.15	
4	Health								
	with profit								
	without profit								
B.	Sub total	1,04,663.38	3,04,115.99	5,96,419	11,58,409	8,95,656.34	22,14,138.35		
C.	Total (A + B)	12,93,292.80	15,03,407.65	2,81,89,020	2,43,81,112	2,24,26,820.81	2,22,67,863.98		
	Riders:								
	Non linked								
1	Health #	592.88	413.95	92,810	58,293	64,087.27	59,137.41	0.01	
2	Accident # #	787.65	848.61	4,82,493	403,327	4,94,009.34	5,41,716.66		
3	Term	186.52	144.52	38,680	31,535	29,812.91	23,880.72		
4	Others	365.59	467.72	80,726	138,662	37,151.15	38,183.61		
D.	Sub total	1,932.62	1,874.80	6,94,709	631,817	6,25,060.68	6,62,918.40		
	Linked								
1	Health #	135.51	193.80	16,720	28,160	35,794.20	64,988.09	0.01	
2	Accident # #	81.95	109.21	50,221	95,231	72,187.14	66,619.70		
3	Term	109.59	65.48	12,293	7,798	22,941.80	14,315.04	0.01	
4	Others	80.86	94.91	15,163	18,134	1,693.31	1,935.05	0.01	
E.	Sub total	407.91	463.40	94,397	149,323	1,32,616.45	1,47,857.87		
F.	Total (D + E)	2,340.54	2,338.20	7,89,106	781,140	7,57,677.13	8,10,776.27		
G.	**Grand Total (C + F)	12,95,633.34	15,05,745.85	2,81,89,020	2,43,81,112	2,31,84,497.94	2,30,78,640.25		

GROUP NEW BUSINESS — SINGLE PREMIUM (INCLUDING RURAL & SOCIAL) 2004-2005 (PROVISIONAL)

(Rs lakh)

Sl No.	PARTICULARS	PREMIUM		POLICIES		LIVES COVERED		SUM ASSURED		AVERAGE FOR 2004-05	
		2003-04	2004-05	2003-04	2004-05	2003-04	2004-05	2004-04	2004-05	Premium per policy	Average sum assured
	Non linked*										
1	Life										
a)	Group Gratuity Schemes										
	with profit										
	without profit	99,731.92	1,04,282.83	2,387	2,203	4,33,238	5,70,718	2,63,670.19	2,84,860.66	47.34	259
b)	Group Savings Linked Schemes										
	with profit										
	without profit	3,488.81	1,875.27	1,041	675	1,74,258	1,35,101	1,66,298.41	1,26,679.15	2.78	200
c)	EDLI										
	with profit										
	without profit	310.30	272.52	1,077	990	2,87,626	5,43,330	1,22,653.11	1,59,544.43	0.28	549
d)	Others										
	with profit	29.00		1		2,197		14,019.00			
	without profit	33,753.84	52,978.26	11,373	14,522	37,15,230	74,12,858	17,21,943.75	36,94,114.64	3.65	510
2	General Annuity										
	with profit	42,601.70	85,053.34	32	7	9,388	5,780			12,150.48	826
	without profit	1,11,007.42	59,146.14	1	10	13,916	11,284	470.30		5,914.61	1128
3	Pension										
	with profit										
	without profit	83,198.02	96,493.52	441	214	1,44,862	25,889	1,412.20		450.90	121
4	Health										
	with profit										
	without profit										
A.	Sub total	3,74,121.01	4,00,101.88	16,353	18,621	47,80,715	87,04,960	22,90,466.96	42,65,198.88		
	Linked*										
1	Life										
a)	Group Gratuity Schemes										
	with profit										
	without profit	546.94	491.10	4	12	813	1,021		8.31	40.93	85
b)	Group Savings Linked Schemes										
	with profit										
	without profit										
c)	EDLI										
	with profit										
	without profit										
d)	Others										
	with profit										
	without profit	196.33	397.69		2		1,623		16.61	198.85	812
2	General Annuity										
	with profit										
	without profit		314.47				14		302.88		
3	Pension										
	with profit										
	without profit	49.93	182.81	1	1	376	10			182.81	10
4	Health										
	with profit										
	without profit										
B.	Sub total	793.20	1,386.08	5	15	1,189	2,668		327.80		
C.	Total (A + B)	3,74,914.21	4,01,487.95	16,358	18,636	47,81,904	87,07,628	22,90,466.96	42,65,526.69		
	Riders:										
	Non linked										
1	Health #	87.19	52.62	37	56	8,728	33,856	2,615.00	2,13,714.09	0.94	
2	Accident # #	20.95	64.04	38	66	9,202	71,295	1,579.00	1,60,303.83	0.97	
3	Term										
4	Others										
D.	Sub total	108.14	116.66	75	122	17,930	1,05,151	4,194.00	3,74,017.93	0.96	
	Linked										
1	Health #										
2	Accident # #										
3	Term										
4	Others										
E.	Sub total										
F.	Total (D + E)	108.14	116.66	75	122	17,930	105,151	4,194.0	3,74,017.93	0.96	
G.	**Grand Total (C + F)	3,75,022.34	4,01,604.62	16,358	18,636	47,81,904	87,07,628	22,94,660.96	46,39,544.61		

GROUP NEW BUSINESS — NON SINGLE PREMIUM (INCLUDING RURAL & SOCIAL) 2004-2005 (PROVISIONAL)

(Rs lakh)

Sl No.	PARTICULARS	PREMIUM		POLICIES		LIVES COVERED		SUM ASSURED		AVERAGE FOR 2004-05	
		2003-04	2004-05	2003-04	2004-05	2003-04	2004-05	2003-04	2004-05	Premium per policy	Average sum assured
	Non linked*										
1	Life										
a)	Group Gratuity Schemes										
	with profit	5.23		2		213		203.26			
	without profit	11,768.28	2,578.21	64	26	54,607	13,975	11,787.34	4,075.68	99.16	538
b)	Group Savings Linked Schemes										
	with profit										
	without profit	2,684.63	1,758.98	23	1	1,96,293	24,240	4,04,834.80	91,378.00	1,758.98	24,240
c)	EDLI										
	with profit		74.04		57		29,293		29,726.38	1.30	514
	without profit	356.99	539.13	80	205	1,44,473	2,78,770	97,036.78	2,25,631.27	2.63	1,360
d)	Others										
	with profit		41.66		25		29,361		30,252.13	1.67	1,174
	without profit	3,330.44	5,865.86	794	4,197	10,59,976	17,24,647	12,60,148.08	18,63,964.67	1.40	411
2	General Annuity										
	with profit										
	without profit	6,746.73		17	3	3,338	1,766	6,746.73	854.50		589
3	Pension										
	with profit										
	without profit	264.69	293.72	5	7	406	226			41.96	32
4	Health										
	with profit										
	without profit										
A.	Sub total	25,156.99	11,151.60	985	4,521	14,59,306	21,02,278	17,80,756.99	22,45,882.62		
	Linked*										
1	Life										
a)	Group Gratuity Schemes										
	with profit										
	without profit	2,421.26	17,923.53	14	171	8,755	1,35,115	3,369.03	21,793.52	104.82	790
b)	Group Savings Linked Schemes										
	with profit										
	without profit										
c)	EDLI										
	with profit										
	without profit										
d)	Others										
	with profit										
	without profit	83.75	355.49	1	10	50	179	91.46	275.24	35.55	18
2	General Annuity										
	with profit										
	without profit		2,578.18		7		1,994		2,578.18	368.31	285
3	Pension										
	with profit										
	without profit	73.60	4,395.40	3	64	3,229	9,964		1,750.13	68.68	156
4	Health										
	with profit										
	without profit										
B.	Sub total	2,578.61	25,252.60	18	252	12,034	1,47,252	3,460.49	26,397.07		
C.	Total (A + B)	27,735.60	36,404.20	1,003	4,773	14,71,340	22,49,530	17,84,217.48	22,72,279.68		
	Riders:										
	Non linked										
1	Health #	18.90	26.05	21	20	5,361	5,818	14,436.99	15,466.45	1.30	
2	Accident # #	36.37	44.26	28	31	24,712	24,720	86,827.67	1,31,063.08	1.43	
3	Term	2.04	0.13	3	1	459	37	808.00	23.01	0.13	
4	Others	2.01	1.43	3	6	16,396	2,184	1,123.41	15,362.01	0.24	
D.	Sub total	59.33	71.86	55	58	46,928	32,759	1,03,196.07	1,61,914.55	1.24	
	Linked										
1	Health #										
2	Accident # #										
3	Term										
4	Others										
E.	Sub total										
F.	Total (D + E)	59.33	71.86	55	58	46,928	32,759	1,03,196.07	1,61,914.55	1.24	
G.	**Grand Total (C + F)	27,794.93	36,476.07	1,003	4,773	14,71,340	22,49,530	18,87,413.55	24,34,194.23		

IRDA Guidelines for IBNR Reserving

IRDA, in a circular dated June 8, 2005 to all general insurers and the reinsurer, has outlined guidelines for the estimation of IBNR Claims provision under the General Insurance Business. The guidelines, effective for financial statements for the year 2005-06 and after, have been issued to enable the Authority to assess the appropriateness of the estimation and to facilitate review.

Circular No.08/IRDA/ACTL/IBNR/ 2005-06 dated 6.5.2005 is superseded by the new circular.

Issuing the circular, the Chairman, IRDA said that while IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000 relating to valuation of liabilities for General Insurance Business require that reserve for claim incurred but not reported (IBNR) shall be determined using actuarial principles and also shall be certified by the insurer's appointed actuary, in the past it has been observed that there was no means of knowing whether the certification was supported by adequate data analysis, the methodology followed in the estimation and what factors were taken into account in the estimate of reserves.

In the absence of such information it was not possible to assess the appropriateness of the estimation of the reserves for IBNR claims. It has therefore, become necessary to issue suitable guidelines in this respect which shall be followed by the General Insurers and their Appointed Actuary to enable meaningful review of such estimates by the Authority.

The circular contains annexures for the mathematical estimation of IBNR Claim Provision, the Report of the Appointed Actuary on estimation of reserves for IBNR Claims, the Statements that are required to be furnished to the Authority and the Procedure to be followed for furnishing the Appointed Actuary's report on the estimation of reserves for IBNR Claims

Extracts:

Chapter 1

GUIDELINES ON MATHEMATICAL ESTIMATION OF IBNR CLAIMS PROVISION

Introduction

1.1 The purpose of these guidelines is to specify an approach to the determination of IBNR in a logical manner and for compilation of data required for such determination.

1.2 These guidelines are relevant to determination of IBNR provisions for direct insurance and facultative reinsurance accepted business. Estimation of IBNR on treaty accepted and Excess Loss accepted business requires other methods more appropriate to the nature of the portfolio and its claims development pattern. Likewise, estimation of IBNR for specialised business such as crop insurance or credit guarantee insurance will require other methods more appropriate to the nature of business.

> The guidelines have been issued to enable the Authority to assess the appropriateness of the estimation and to facilitate review.

1.3 In these guidelines, the term IBNR covers both provisions for claims not reported as well as inadequate provision for reported claims, called IBNER. It is not necessary to establish separate reserves for IBNR and for IBNER so long as the method used will take into account both elements.

1.4 There are several possible methods for determination of the provision for IBNR claims. The method most appropriate in a particular case will depend on the nature of the business and claims development pattern. The method stated in these guidelines is the preferred method and is generally suitable to most sets of data. Where the Appointed Actuary considers the method stated in these guidelines to be not suitable, he should set out the reasons for such conclusion and provide justification for the alternative method proposed to be used, being considered more appropriate. Where the method used is not one of the well-known methods, the Appointed Actuary should also describe the method and the underlying assumptions in that method.

1.5 Every mathematical method of estimation is based on a set of assumptions. So, the validity of the assumptions underlying the method proposed to be used should be fully set out and validated sufficiently to lend credibility to the exercise.

1.6. Calculation of provision for IBNR should be done separately for each year of occurrence and the figures should be aggregated to arrive at the total amount to be provided.

1.7 When the mathematics produces a negative value for the estimate of IBNR provision for any year of occurrence, it is incorrect to automatically assume that the company is over-providing. The validity of the underlying assumptions should be re-examined. Other tests of credibility of the results should be applied. The incurred claims ratios derived after the estimation of IBNR should be reviewed in the general background of the ratios for the insurer concerned over the years and also the ratios for other insurers in the market for the same years.

There should be a logically identifiable reason to support the findings. It is prudent to ignore negative values of IBNR provision.

Examination and validation of basic data

2.1 Integrity and completeness of data is essential to an acceptable estimation of IBNR provision based on such data. Therefore, an examination of the data should precede the work of estimation of IBNR provision. Although it is the responsibility of the management of the insurer to provide complete and accurate data as required by the appointed Actuary, the Appointed Actuary should apply such checks as practically possible, to ensure the quality and completeness of the data.

2.2 As suggested in the guidance note on collection of data on claims development, it is important to ensure homogeneity of data with regard to nature of business and claims development pattern. Therefore, data should be examined separately for each of the classes set out in the guidance notes. If data of any class is aggregated with data for another class, care should be taken to see that the two classes are homogeneous in nature. In respect of Motor insurance business, it may be possible to compile data separately by class of vehicle and by scope of cover and by nature of claim. Provided the quantum of data is statistically adequate for projection work, this may be done. In respect of long-term insurance policies, the Appointed Actuary should adopt an appropriate basis to ensure that the earned premium for the year alone is used in the calculations. In respect of insurance plans including cover in more than one subclass such as Householders' Comprehensive insurance, the system adopted by the insurer for classification of the business and the related premium should be consistently applied to data for all years used in the estimation process.

2.3 The underwriting policy of an insurer has a material effect on the nature of its portfolio and consequently, on the claims development pattern. Therefore, the Appointed Actuary should first examine the changes in underwriting policy over the period of observation and in particular, the changes made in current underwriting policy. The impact of such changes on the claims development pattern and claims ratio should be examined.

It is important to ensure homogeneity of data with regard to nature of business and claims development pattern.

2.4 In the above context, the progression of premium over the recent years should be

examined. Where the premium income shows significant fluctuation, the reasons for it should be examined. In particular, the impact of the types of risks being underwritten more actively, on the claims development should be taken into account. One of the important underwriting factors is the extent of policy deductible. If the average level of deductible has undergone material change over the recent years, its impact on the claims development should be taken into account.

2.5 In respect of motor insurance business, the composition of the portfolio by type of vehicle is material to the claims development pattern. Where the portfolio has changed materially, over recent years, its impact on the overall claims development should be taken into account unless data is split into several sub-divisions.

2.6 Compilation of data on an underwriting year basis instead of year of occurrence basis may be proposed in some cases. Where this basis is followed the Appointed Actuary should support the reason for change of basis on objective reasons.

Claims handling practices

3.1 A detailed review of the claims handling practices from the following aspects should be made. Where material changes are identified, their impact on the claims development pattern should be taken into account.

3.2 Although the law requires every claim to be recognized on first intimation, the way this is implemented in practice may differ from one company to another. The impact of inadequate provision for claims on claims development will be significant and should be taken into account.

3.3 Besides recognition of claims, the practice followed by the insurer to determine the provision to be made and the mechanism to review such provision as the claim develops are also important factors in claims development. Also, if the insurer has the practice of downsizing the claims provision in cases where there has been no movement in the claim over a certain period, it will be an important factor in claims development.

3.4 Besides studying the practice with regard to recognition, reserving and review of reserve, the claims settlement practice of the insurer

should be studied. In particular, the company's practice in speed of processing for settlement, fairness in settlement offers, attitude to litigation, approach to interim payments and effectiveness of recovery action both by sale of salvage and through recoveries from third parties, are all material to the claims development pattern. For example, financial problems can get reflected in slower development of claims paid and unless interpreted properly, they will lead to significant under-estimation of ultimate claims incurred ratios.

3.5 When studying the above aspects, it should be remembered that any set of practices that have been stable, will be reflected in the claims development pattern. Hence they may not present as much of a problem in estimation as any material changes in practices. The impact of such changes should be evaluated.

3.6 Methods that work on incurred claims are subject to far more uncertainties than methods that rely on progression of paid claims due to the uncertainties of claims estimation and reserving. Hence the Appointed Actuary should invariably work on paid claims data as the core basis of the estimation process. However, the Appointed Actuary may do another calculation using incurred claims as a point of comparison, if he so desires.

3.7 The claims development pattern can be materially affected by the occurrence of unusual events over the period of observation such as:

- Individual large claims;
- Catastrophic events causing a large number of claims;
- Changes in Law affecting the incidence and size of claims; and
- Impact of external factors on the average size of claims.

3.8 When looking at estimation of IBNR on a "net of reinsurance" basis, note should be taken of any changes in reinsurance protections and changes in size of retentions over recent years.

Allowance for trends

4.1 In order to make adequate allowance for trends, the following aspects should be studied:

(i) Composition of portfolio;

(ii) External factors such as economic environment, inflation, changes in legal, political or social conditions;

Besides studying the practice with regard to recognition, reserving and review of reserve, the claims settlement practice of the insurer should be studied.

(iii) Insurer's underwriting policy; and

(iv) Insurer's claims settlement practice.

4.2 A significant indicator of claims experience is the frequency of claims occurrence and the average size per claim paid and per claim outstanding. These should be studied and any variations observed should be looked into.

Preferred method for estimation of IBNR

5.1 Based on data submitted for successive years, the cumulative development of claims picture should be compiled. It can be tabulated as shown in Form IBNR-B-1/2.

5.2 The cumulative claims paid as at the end of 24 months in respect claims relating to events that occurred in the year from 1 April 2002 to 31 March 2003 is the total of claims relating to the "current year" in the statement of claims for the year ending 31 March 2003 and claims paid in the "first preceding year" in the statement of claims for the year ending 31 March 2004; and so on. The cumulative statement is thus built up by putting together information from statements of claims for successive years.

5.3 The cumulative statement of claims development shows the way the claims paid picture develops over time. Assuming that the pattern of claims development will remain stable, it is possible to project to the completely developed claims amount using the progression of "link ratios" derived from the available data. The amount of IBNR will be the estimated ultimate claims cost less amounts paid so far and amount provided as outstanding on the date of estimation.

5.4 If there were changes in portfolio or underwriting or claims settlement practices, it may be better to use the latest available year's link ratios rather than the average ratios.

5.6 The estimation process should not discount the estimated future development of paid claims to the current date nor should it load the claims outstanding specifically to provide for inflation in the future cost of claims, other than the factor already inherent in the estimation process.

Tests of credibility

6.1 The exercise of estimating the provision for IBNR will not be complete without applying the tests of credibility to the results produced. These include looking at the frequency of claims occurrence, ultimate incurred claims ratios,

average cost per claim paid and per claim outstanding etc.

6.2 The ultimate incurred claims ratios for the successive years should be credible as compared to ratios of other insurers in the market and for the same insurer over time. There should be logical explanations for any variations or sharp fluctuations. If the calculations produce progressively reducing ultimate claims ratios, they indicate a deficiency of the mathematical model. It may then be necessary to over-ride the results by alternative methods such as ultimate loss ratio method or Bornhuetter-Ferguson method.

6.3 Since insurers do not normally consciously over-provide for claims and since even with utmost diligence there will be claims that have occurred but have not yet been intimated to the insurer, it is inappropriate to accept any negative values for IBNR produced by the mathematics. To avoid such an error, estimation of IBNR should be made separately for each year of occurrence. Negative values of IBNR for any year should be ignored.

6.4 An essential check on the credibility of the estimation exercise is to see how the claims developed during the preceding twelve months as compared to the projection and estimation made last year. The outstanding claims provision and provision for IBNR made at the last Balance Sheet date should be compared with the aggregate of claims paid during the year, claims provided as outstanding at the end of the year and the provision for IBNR claims produced by the formula.

6.5 Most estimation methods produce less reliable results for the most recent years.

Hence the results for the more recent years have to be revised based on the Actuary's knowledge of the business, the company's portfolio and claims settlement practices and the claims ratios of other insurers in the market.

Chapter 2

REPORT OF THE APPOINTED ACTUARY ON THE ESTIMATION OF RESERVE FOR IBNR CLAIMS AS AT 31 MARCH

Name of insurer:

Name of Appointed Actuary:

Class of business:

Section I – The insurer and its business:

A significant indicator of claims experience is the frequency of claims occurrence and the average size per claim paid and per claim outstanding. These should be studied and any variations observed should be looked into.

1.1 How active is the insurer in that class of business? Has the growth of premium income been steady and reasonable? Fluctuations in growth rates or high or low growth rates may be indicative of a change in the composition of business or changes in underwriting policy.

1.2 What is the underwriting policy of the insurer in respect of:

i. Selection of risks

ii. Rates and deductibles

iii. Delegation of underwriting authority.

1.3 Has the underwriting policy remained stable over the last six years? Have there been any changes in key underwriting personnel and how would that have impacted on the underwriting policy of the insurer?

1.4 What has been the claims processing and settlement policy of the insurer in the matter of:

i. First recognition of claim;

ii. Provision for a claim where no information or inadequate information on facts is available;

iii. Periodicity of review of the provision for a claim;

iv. Negotiation of bodily injury claims relating to motor accidents;

v. Processing and settlement of claims; and

vi. Pursuit of recovery or sale of salvage.

1.5 Has the claims processing and settlement policy remained the same over the past six years? Have there been any changes in key claims personnel and how would that have impacted on the claims settlement practice of the insurer? If so, comment on how the impact of these changes have been taken into account?

1.6 Has the insurer passed through cash flow or financial problems over the observation period? If so, has it affected the insurer's underwriting or claims settlement practices?

Was there a significant slowing down in claims settlements?

1.7 Were the observed claims data affected by catastrophic events such as earthquake, flood, windstorm, individual large claims etc.? Were there significant changes in the business environment such as a severe economic recession that would have affected the business experience? If so, how have they affected the observed claims figures?

1.8 Was there any change in the general business and insurance industry conditions in matters such as legislative environment, competition, consumerism, levels of court awards etc.? If so, the impact of these changes should be commented upon.

Section II – The data

2.1 If the data is not separately compiled for each class of general insurance business as required by the guidance notes, then please comment on the reasons for variation.

2.2 Please comment on the source of data and steps taken to ensure that the data is consistent, reliable, complete and tallies with the audited accounts.

2.3 Please comment on the observed trends in the growth of premiums, frequency of loss occurrence, average cost per claim paid and per claim outstanding, speed of emergence of claims and speed of settlement. Please also state how these have been taken into account in the selection of the process of estimation.

2.4 Did any individually large claims affect the claims development figures? If so, how are they taken note of in the estimation process?

2.5 Is the estimation of IBNR done on a "net of reinsurance" basis? If not, describe the process followed to determine the amount to be provided net of reinsurance. Was there any material change in the reinsurance programme? If so, describe the manner in which it was allowed for in the estimation process. If data on net of reinsurance basis is not readily available, it is open to the actuary to work on the IBNR estimate on a gross basis and work on the estimate of IBNR for the share of reinsurance ceded, if that is more easily possible.

Section III – The method

3.1 Please describe the method used for estimation of IBNR. If the method used now is different from the method used previously, please state the reason for change.

3.2 Please state the assumptions underlying the method and to what extent the validity of the assumptions was verified.

3.3 Where the method used is not commonly understood, please explain the methodology and provide adequate working sheets to understand the calculations and results.

An essential check on the credibility of the estimation exercise is to see how the claims developed during the preceding twelve months as compared to the projection and estimation made last year.

3.4 Please cross-check the result using another method, preferably, the chain-ladder method and comment on the outcome. However, if the Appointed Actuary chooses to use the chain-ladder method for estimation, then he may check on the estimate using any other method considered by him to be suitable for the purpose.

Section IV – Evaluation of the results

4.1 Please describe the tests of logic applied to the results and the results of the tests.

4.2 How do the figures of outstanding claims as per the estimation process compare with the actual provisions? If the calculated estimates are lower than the actual provisions, please advise the further tests applied to evaluate the validity of the results.

Section V

5. Comment on calculated incurred claims ratios for the insurer over the years and also as compared to other insurers in the market. In particular, please comment whether the claims ratios for the more recent years are logical. If not, please state how the estimation process was modified to achieve more credible results.

Attachments

6. The data collected from the database of the insurer, the compiled cumulative figures, the calculation sheets and the final results should be attached to the report.

Certification

7.1 The Appointed Actuary should not put forward or certify any figures, which lack credibility, with serious reservations.

7.2 The Appointed Actuary should certify that he has checked the data to the best of his ability and is satisfied that they are consistent, reliable and complete and that the assumptions underlying the method used for estimation of IBNR are valid.

7.3 The report should be signed with date by the Appointed Actuary. The Appointed Actuary should also secure a certificate from the Principal Officer and attach it to his report.

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Non-standard Settlements

—A Standard Measure

Gnanasundaram Krishnamurthy

Much has been said by management gurus on marketing concepts and strategies, and many an idea have Indian organisations – both public and private –toyed with. The banking and insurance sectors have been no exceptions. The fact that customer satisfaction is the yardstick to measure the success of marketing has now come to be more or less accepted by corporate India.

In service organisations such as insurance, customer satisfaction is typically achieved through effective after sales service, the settlement of claims playing the most important role in this direction, as a primary service. However, since insurance is but a contract, the insurer honours it only within the specified terms and conditions of the policy.

While this cannot be disputed, the insurer cannot satisfy the end user by making settlements of standard claims alone, confined by the four walls of the policy contract. As a matter of good business policy, therefore, public sector insurers have provisions to settle claims on a non-standard and ex-gratia basis. It is believed that such provisions do exist in the private sector also. But this should not exist on paper alone.

In 2000, General Insurance Corporation of India, as a holding company, issued guidelines to PSU insurers on the disposal of compromised claims, which cannot be treated as standard, permitting settlement up to a maximum of 75 per cent of the assessed claim.

However, despite these guidelines, many cases come before the consumer forums and Ombudsman, where insurers could have invoked these guidelines. Such cases typically end with the insurers being directed to consider the disputed claims on a non-standard basis.

Similar is the experience in respect of ex-gratia payments. These are made as a concession without any legal obligation and therefore are not always made in full. While in LIC, the power to make ex-gratia payments is vested in the controlling offices with monetary limits, in the PSU non-life companies, only the Boards are competent to consider these payments.

More often than not, while considering settlement of claims, the operating offices are oblivious to these provisions and decide only to settle standard claims and repudiate others, with no thought process taking place to examine ex-gratia payments, either at their level or at the higher prescribed level.

This, more often than not gives rise to disputes. Centralising ex-gratia payments at the Board level is all right for corporate claims involving huge sums of money, but it is a non-starter so far as small individual policyholders are concerned.

The insurer cannot satisfy the end user by making settlements of standard claims alone, confined by the four walls of the policy contract. As a matter of good business policy insurers have provisions to settle claims on a non-standard and ex-gratia basis.

Although it was a good move by the Government to arm ombudsmen with the power to grant ex-gratia payments, it is primarily the function of the companies, as it is they who are concerned with customer satisfaction, being the marketing organisations they are.

The consumer disputes redressal forums also do not hold the power to make ex-gratia payments in disputed claims. In fact, in case no. 551/A of 2000, between LIC of India and Smt. Rekha Dixit, the West Bengal State CDRC, Kolkata, set aside the order of the District Forum directing LIC to make ex-gratia payment, holding that the Forum lacked jurisdiction to grant such payments.

While ombudsmen do hold such powers, such a provision should not prompt the companies to close their eyes to the existence of enabling provisions in their own organisations and make the end user run to grievance redressal agencies for every non-standard claim. Decentralisation of powers to make speedy non-standard and ex-gratia payments, *suo motu*, directed at increasing customer satisfaction levels, particularly amongst small, individual policy holders, will go a long way in improving the image of both public and private sector insurers. The insurers will do well to devise ways and means to make this happen as a matter of course.

How big an interest

Delay in claims settlement is a frequent complaint of policyholders, in both the life and non-life insurance segments. Since it bites the small individual policyholders more, the Government has termed it, among other things, a grievance that can be brought before the Insurance Ombudsman, under its Redressal of Public Grievances Rules, 1998.

Equity demands that in case of delayed settlement of claims, the policyholders be adequately compensated for the loss of interest, which they otherwise would have earned had there been prompt settlement of claims. Delay is not a dispute but a grievance. Hence, when the Ombudsman is approached with this grievance, the merit of the case cannot be gone into, as the settlement is still pending and a meaningful award can, therefore, be only towards alleviating the grievance of the complainant by directing the insurer to take a decision early and pay interest as and when the claim is settled.

The calculation of interest involves several factors such as the rate, the period, the minimum period for consideration of settlement and delay on the part of the insured to furnish details and documents. The IRDA, on its part, has laid down rules in this regard in its Protection of Policyholders Interest Regulations, 2002, under clauses 8(4) and 8(5) in regard to life insurance claims and under clause 9(6) in regard to non-life insurance claims.

In the case of life insurance claims, while 'delay' is not specifically defined, clause 8(5) has to be read with clauses 8(2) and 8(3), which allow insurers 15 days for calling for requirements and 30 days for admitting claims after receipt of all documents, respectively. In respect of early claims, six months are allowed for completing investigation.

The question of payment of interest, therefore, arises only beyond 45 days (excluding delay on the part of the claimant) in respect of non-early claims and beyond 210 days (excluding delay by claimant) in respect of early claims requiring investigation.

This stipulation appears more liberal than the industry standards, as LIC pays interest on a delayed death claim payment beyond 180 days in respect of early claims requiring investigation. Further, provision in regard to delayed payment of maturity claims and the rate differential between those specified under clauses 8(4) and 8(5) need to be addressed.

> Equity demands that in case of delayed settlement of claims, the policyholders be adequately compensated for the loss of interest, which they otherwise would have earned had there been prompt settlement of claims. Delay is not a dispute but a grievance.

For payment of interest in respect of general insurance claims, the basic deviation is that delay on the part of insurers in processing the claim is totally ignored as opposed to life insurance claims, as interest as per clause 9(6) is payable only for delayed payment, after receipt of acceptance, beyond seven days.

Clauses 9(1), 9(2), 9(3), 9(4), 9(5) and 9(6), all put together, allow 106 days ordinarily for processing the claim (excluding delay on the part of claimant) (256 days in respect of complicated cases due to additional time given to surveyors).

However, the regulations do not envisage interest payment if there is processing delay beyond the above limits, but direct insurers to pay interest only when the actual payment of claim amount is delayed beyond seven days after receipt of acceptance, which will be few and far between.

Suitable amendments to the relevant clauses will alleviate the end user's agony, particularly the small policyholders of Health, Motor, Fire and Marine insurance.

The author is retired Chairman, LIC and former Ombudsman, Maharashtra and Goa.

Getting Down to Brasstacks

— The nitty-gritty of micro insurance programmes

While the need for micro insurance is undeniable, there are various questions on how to go about it. *Arup Chatterjee* discusses these, while illustrating the basic tenets of each method.

The poor and the socially backward need to be fed, clothed, sheltered and educated. However, to truly ensure their long-term security and happiness, they need to be adequately protected from risks – risks stemming from sudden loss of assets, ill health, accidents or death. Improving the risk management capacity of the poor has come to be viewed an integral part of any poverty alleviation programme.[1]

It is in this context that the idea of micro insurance has caught the attention of policy makers, researchers, non-governmental organisations (NGOs), donor agencies and social scientists involved in tackling poverty. The optimism with the idea of micro-insurance stems mainly from two different sources: one, from the success of micro credit programmes[2] in ameliorating the conditions of the poor in different parts of the world by enabling them to generate income on a sustained basis through asset and/or skill formation;, and two, from the growing recognition of the role risk plays in the lives of the poor, and hence the need to increase their ability in dealing with it. Improving the risk management capacity of the poor has come to be viewed an integral part of any poverty alleviation programme.[3]

Although experiences of the impact of micro insurance schemes is still very limited, available evidence seems to suggest that micro insurance, if properly designed and implemented, can provide an effective mechanism for meeting the requirements related to social and personal security, asset security and the healthcare challenges of the poor. This is in addition to improving their access to financial intermediation services through the mechanism of insurance.

The potential of upscaling, extending and expanding micro insurance programmes depends crucially on the issue of *affordability*, that is, to what extent resources for meeting insurance costs can be mobilised from the people themselves.[4] Limited reach and coverage of the existing micro insurance initiatives by itself is not sufficient to question the affordability of premium by the poor and hence justify the need for subsidising premium. In most cases, institutional rigidities, in particular credit or borrowing constraint, suppress demand for insurance from low-income households who can otherwise afford to pay for insurance.

> One of the common perceptions about the poor is that they are too poor to either save or buy insurance. While this may be true for the poorest of the poor who struggle for survival every day, this need not to be true for those living close to the poverty line.

Insurance is not the only way of dealing with risks[5], and not all risks are insurable[6]. However, life and health risks such as those relating to death, illness, injury, disability and maternity are considered eminently insurable, as these risks are mostly independent or idiosyncratic, i.e. not correlated among community members.[7] Moreover, among several risks facing poor households, life, health and asset risk are considered crucial, as they have a destabilising effect on household finances: directly, by thrusting expenditure in the event of death, illness or any loss or damage to assets; and indirectly, by affecting the income earning capacity of households[8]. Hence the need for a two-pronged strategy: one, aimed at improving the life and health status of the poor, and two, protecting them from the financial consequences in the event of death, illness or loss or damage to assets. For this reason, micro insurance that essentially protects households against the financial consequence of death, illness and loss or damage to assets is regarded as a complement to, and not as a substitute for, other interventions.

Amidst shrinking government budgets, failure of the markets to reach the poor and widespread criticism of levying user charges, community-based arrangements have aroused much interest and hope in meeting social, health and asset security challenges facing the poor, and micro insurance is considered an important financing tool for protecting the poor from adverse financial consequences in the event of sickness. While the out-of-pocket expenditure by way of spot payments in the event of death, accident and repair or replacement of assets imposes great financial hardship on the poor, community-based insurance is seen as an effective way in financing such costs. In fact, some micro finance programmes in Africa have successfully introduced such insurance on a limited scale.

Community-based insurance schemes are usually built around the following characteristics: voluntary membership, non-profit objective, link to a care provider (for example, in case of health insurance, it is often the hospital in the area), risk pooling and relying on an ethic of mutual aid/ solidarity. Their advantage lies in being able to reach low-income people in rural areas and working in the informal sector that are otherwise difficult to reach,

exploit social capital in bringing about greater awareness, correcting for adverse selection and moral hazard problems[9] and encouraging preventive measures, and increased access to insurance facilities. But community-based schemes also have certain weaknesses such as a low capital base, low level of revenue mobilisation, frequent exclusion of the poorest of the poor, small size of risk pool, limited management capacity and isolation from more comprehensive benefits.

A question of affordability

However, the reach of the existing micro insurance schemes is still low and attempts are being made to bring more and more people under its ambit, by upscaling, extending and replicating the schemes. In extending the reach of micro insurance, *demand side* and *supply side* factors and factors relating to *design and development* of scheme are important.[10] This article shall focus only on the demand side factors and in particular on the issue of affordability.[11] In order to increase the access of these people some schemes need to be developed with mechanisms that lower entrance barriers for the poorest, e.g. flexibility in premium collection and exemption mechanisms.

One of the common perceptions about the poor is that the poor are too poor to either save or buy insurance. In other words, the poor are too poor to buy insurance. While this may be true for the poorest of the poor who struggle for survival every day, this need not to be true for those living close to the poverty line. For these people, their apparent inability to join an insurance scheme may not be the result of affordability *per se* but that of institutional rigidities such as credit constraint. In such a situation, easing credit constraint rather than subsidising premium may help improve the reach of micro insurance schemes.

We need to first analyse how a borrowing constraint may affect the demand[12] for insurance in general, and then, show how it influences insurance demand in the case of poor households. The subsistence constraint faced by the poor who can otherwise afford insurance, interferes with their purchase decision. If the poor individual is allowed to borrow against his future income his demand for insurance would go up.

In needs to be stressed that the setting we outline above is applicable not to the poorest of the poor for whom affordability is indeed the major issue and thus are dependent on public subsidy.[13] This setting is applicable to those who, though currently living above or on the poverty line, are likely to fall into poverty trap in the event of any major health shock.[14] If such people have access to credit, their need for insurance may get translated into effective demand for insurance, which fails due to their subsistence constraint, and through purchase of insurance they may be able to protect themselves against the risk of falling into poverty trap.

The order of priority between savings and credit on one hand and insurance on the other is critical. Whereas the importance of financial services (savings, insurance and credit) in risk management literature is well recognised, it is not clear how to prioritise the allocation of public funding and effort between savings and insurance.

There exists circularity between *poverty* and *vulnerability*: that is, the poor people are more vulnerable (exposed to risk) and their vulnerability is the cause of their poverty. In other words, the link runs both ways. The presence of a credit constraint might be reinforcing this link, and this link can be severed by the easing of such a constraint. Another aspect to be examined in this context is in understanding the *order* of priority between savings and credit on one hand and insurance on the other. Whereas the importance of financial services (savings, insurance and credit) in risk management literature is well recognised, it is not clear how to prioritise the allocation of public funding and effort between savings and insurance. That is, whether access to voluntary, flexible withdrawal of savings and credit should receive a higher priority (over insurance) or should insurance be assigned higher priority than savings and credit. Savings and credit functions should at least be undertaken *concurrently* with insurance, if not before insurance. Perhaps, it is appropriate to embed micro insurance function in the micro-credit schemes that are already in place.

Nobody doubts the need for micro insurance and government intervention for the poor. Where affordability is the issue, government subsidy is clearly needed and an important policy issue here is the *extent* and the appropriate *form* that subsidy should take:

(i) Public intervention has an important role in upscaling, extending and replicating micro insurance schemes that have emerged as a promising route for financing. One important role is in removing of institutional rigidities, in particular in easing credit constraint. Removing these rigidities may be an appropriate way of translating latent demand into effective demand for insurance. However, this channel is likely to work for the poor who are currently able to meet their basic needs but face the risk of falling into poverty trap. For people who can afford premium but for the institutional rigidities, subsidising premium may not be an appropriate strategy. In fact, subsidising premiums bears a disadvantage that it may aggravate associated moral hazard problems.

(ii) For the poorest of the poor, who are already below the poverty line, easing of credit is unlikely to

generate insurance demand. If credit is made available to them, it will in all probability be used in meeting their current basic needs than for hedging against risks in the future. The poorest of the poor need direct public support for meeting their security needs. For e.g. their healthcare needs can be met either directly through free access to public healthcare services or indirectly by integrating them into micro insurance schemes and subsidising the premium. The idea behind integrating the poorest of the poor into micro insurance schemes is to enlarge the risk pool and thereby make the existing schemes more stable. Without subsidising premium, the poorest of the poor can hardly be integrated into such schemes, since no resource pooling (distinct from risk pooling) can be effected by selling insurance to them. However, the choice of the strategy would depend on the relative merit of each strategy.

(iii) Some inferences can be drawn on the design and the development of micro insurance schemes. For example, schemes that allow for flexibility in payment of premium (small amounts collected more often; allowing premium in kind as well) are more likely to succeed because such flexibility can in fact serve the role of credit.[15] Perhaps, credit facility can be in-built into the schemes by having a separate pool that can be used for paying premiums of members who are unable to make payments in time. Also, linking credit exclusively for the payment of premium may also check against its dissipation in meeting other less urgent needs.

(iv) More broadly, public intervention can play an important role in risk reduction activities such as improved sanitation, preventive healthcare and controlling for communicable diseases and accidents. The burden of these shocks falls inequitably on the poor. Public intervention can contribute to the success of micro insurance schemes by insuring against covariate risks that undermine micro insurance arrangements against uncorrelated shocks. Moreover, public intervention can also make micro insurance programme viable at least in the early stages of their formation when, because of limited risk pooling capacity of such programmes and because of low capital base, these programmes may have difficulty in breaking even. Reinsurance is one of the ways in which public intervention could contribute to the viability of the schemes. Public intervention could also bring about awareness among the people about protection through insurance.[16]

In the context of the discussion on extending the reach of micro insurance schemes, which hold promise for reducing shocks facing poor households, it is essential to make a distinction between those who can afford insurance and those who cannot. Lack of demand for insurance need not necessarily be the result of affordability *per se*, and thereby justifying the need of government subsidy, but may be the result of other institutional rigidities such as borrowing or credit constraint. This would mean, that it is probably wise to look for potentials to embed micro insurance in existing micro credit schemes rather than building micro insurance schemes from scratch.

> The transaction costs associated with micro insurance are undeniably high, and experience indicates that it is difficult to offer effective and sustainable insurance products for poor people. Yet, the same could have been said about the micro credit sector 15 years ago.

Critical groundwork

A micro finance organisation wishing to start an insurance programme for its members needs to do some preparatory groundwork. The three broad steps involved in setting up an insurance scheme are:

i. Carrying out an insurance needs assessment of the micro finance programme members;

ii. Designing an appropriate scheme for the members;

iii. Doing the preparatory groundwork before implementing the scheme.

This involves the following:

i. Evaluating the types of risks faced by members –typically these include sickness, disability, death loss of assets due to natural and social disturbances.

ii. Assessing the probability of occurrence, e.g. what percentage of the members can be expected to be hospitalised in one year;

iii. Assessing the average financial loss that is suffered in the case of each of these risks.

The managers and staff of a micro finance programme may have a sense of the above without undertaking any formal survey. However, if the organisation wants to institute an insurance scheme, gathering this information in a more systematic way is required. In addition, the organisation should try and assess the members' *ability to pay* the insurance premium and their *willingness to pay* this amount.

To design an insurance scheme for its members, an organisation has to make choices on the following:

i. Determining the risks to be covered - most organisations begin by offering coverage for one type of risk, e.g. life insurance against natural or accidental death. After this is stabilised, other types of coverage are added.

ii. Deciding whether to link up with an insurance company or run the scheme independently;

iii. Deciding whether the scheme be

made mandatory for all members or voluntary.

Deciding between a scheme which is linked with the insurance company or one that is delinked from it, and between a mandatory versus voluntary scheme, has different implications for the micro-finance institution. These are discussed below:

In a de-linked insurance scheme, the MFI has to take complete charge of managing all aspects of the scheme and has to bear all the risk.

It is recommended that an MFI link up with an insurance company, at least for the first few years. This is because a typical MFI works with a limited number of persons in a restricted geographical area. As discussed, insurance is financially sustainable if the risks that it covers are spread over large numbers and also spread geographically.

DECISION I: TO LINK UP WITH INSURANCE COMPANY OR NOT	
Option A: Scheme linked up with insurance company	
TASKS OF MFI	**TASKS OF INSURANCE CO.**
Educate members about scheme premium amount and the sum insured	Design the insurance scheme – i.e. the
Enroll members and collect premium	Manage premium funds
Forward premium to insurance company	
Help members with filing claims (getting proper documentation, submitting documentation to insurance company, etc.)	Assess claims submitted by the insured members
Follow up with insurance companies for claims submitted	Pay out claims to the insured members
Send claim amounts received from insurance company to members	
Monitor the claims ratio – i.e. the amount received in claims as against the premium paid to the company	
Option B: Scheme de-linked from insurance company	
ADVANTAGES FOR MFI	DISADVANTAGES FOR MFI
The MFI does not have to develop expertise in the area of insurance	The premium amount is not available for lending;
Financial risk is borne by the insurance company.	Norms for claim payment not always sensitive to informal sector;
	Claims settlement may be prolonged;
	Loss of potential profits of the insurance programme

In the Indian case, in order to promote the micro-insurance concept, it is necessary to bring in suitable secondary legislation so that insurers can design suitable micro insurance products besides providing incentives to insurers. Micro insurance products need to be pre-defined in terms of types of coverage, age of entry, minimum and maximum coverage as well as the terms cover, and they shall have to be filed with the Authority as per the File and Use guidelines. Typically, the the coverage in the case of life insurance may range from Rs. 10,000 to 50,000 and the term from one to five years. In case of general insurance for huts, livestock and agricuktural implements, it may range from Rs. 5,000 to 20,000; health insurance from Rs. 5,000 to 50,000 and personal accident from Rs. 10,000 to 50,000. Selling these products should form part of the rural and social obligations of an insurer as per provisions of the Insurance Act, 1938.

Sops for agents

In addition, the qualification, training, and examination requirements for agents and employees of brokers engaged in selling micro insurance products needs to be relaxed along with amendments in the Insurance Act to permit payment of higher remuneration by way of incentivising people to sell such products. Otherwise the small ticket size may not adequately compensate for the efforts made in concluding a sale and thereafter providing any value added service.

To improve penetration it would perhaps be worthwhile to consider tie-ups between life insurers and general insurers to cross sale each other's defined micro insurance products. However, as a matter of abundant caution, one needs to ensure that no agent or broker or any other intermediary is allowed to underwrite any insurance proposal for the purpose of granting insurance cover. A micro insurance agent or an employee of an insurance broker may be allowed carry out the following functions: collection of proposal forms, collection of monies for issuance of contract or remittance of premium, settlement of claims, nominations, and any policy administration service. For popularising the products and increasing its general awareness, insurers must endeavour to see that the local language which is understood by policyholders at large is used.

Micro insurance is a highly technical operation, and this poses many challenges and merits caution. Recognising and being aware of cautionary notes does not imply that one should necessarily be pessimistic about the prospects of micro insurance for micro-finance institutions. Transaction costs in the insurance industry are undeniably high, and experience indicates that it is difficult to offer effective and sustainable insurance products for poor people. Yet the same could have been said about the micro-credit sector 15 years ago.

The challenges that micro insurance poses today simply imply that there is still a lot to learn from the informal

DECISION II: TO MAKE THE SCHEME MANDATORY FOR ALL MEMBERS OR TO MAKE IT VOLUNTARY

Option A: Make the scheme mandatory for all members

ADVANTAGES FOR MFI	CONSIDERATIONS FOR MFI
Premium collection becomes more systematic Accounting of funds collected becomes easier The membership pool is larger, and a lower premium can be negotiated with insurance co. The problem of adverse selection of members (i.e getting a high number of high-risk members) is reduced.	All members may not be willing to join in the beginning (Note: The MFI may benefit from running it with a sub-group on a pilot basis to give it a chance to identify possible problems)

Option B: Let the scheme be voluntary

ADVANTAGES FOR MFI	CONSIDERATIONS FOR MFI
The MFI has to make less effort to convince **all** the members to participate. Members may gradually join as they see insured persons getting the benefit of the schemes.	The greatest danger is that only high risk persons may join the insurance programme If only a small number of members join, the MFI may not be able to negotiate as good a premium as it could for larger group; Administration of the scheme may be more difficult.

economy and from formal insurance providers, and that there are serious institutional issues to consider. It is important to recognise that micro-finance institutions may certainly have much to contribute to the industry, but that they, too, may have a lot to benefit from forging partnerships and developing linkages with, for instance, other insurance providers.

We must look forward, we must commit ourselves to bring about the day when the poor of the world, the hopeful youth, the aged, the street children, the disabled, the rural workers, the slum dwellers, will all be able to experience the spirit while reciting the verses from celebrated poet Gurudev Rabindranath Tagore's poem "Where The Mind Is without Fear," and feel that the mind is indeed without fear.

"..... the mind is without fear.

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End Notes

1 The motivation for the popularisation of micro insurance also comes from the failure of public sector insurers to provide insurance coverage to rural masses by having a profitable portfolio.

2 Although credit and insurance are two very different concepts, it is believed that the success of micro credit shows how the impediments posed by informational asymmetries (giving rise to the moral hazard and adverse selection problems) and those relating to high transaction costs that prevent formal providers of financial services from catering to the low-income section of a society, can be overcome.

3 The motivation for the popularisation of micro insurance also comes from the failure of public sector insurers to provide insurance coverage to rural masses by having a profitable portfolio.

4 Unlike micro credit where transfer in the first instance takes place from the credit provider to the poor, in case of insurance a reverse transfer takes place, i.e., from the poor to the insurance provider (for a promise of covering the loss resulting from a particular event). Therefore, in the context of insurance *affordability* becomes an important issue.

5 Depending on an individual response to dealing with risks, the literature classifies all risk management practices into three broad groups: risk reduction (RR), risk mitigation (RM) strategies and risk coping (RC) strategies. The former two strategies are *ex ante* risk management strategies (that is, used before a risky event takes place) whereas the later one is an *ex post* strategy (that is after the event takes place). Insurance, similar to savings and borrowings, is a part of risk mitigation strategy.

6 Insurability of risks depends on the characteristics of risk. Literature on risk management approach classifies risks alone several lines. For example, depending on the nature of risks: whether risk is independent vs. correlated, high frequency low cost vs. low frequency high costs, or depending on the appropriate agency handling risks.

7 Unlike many life and health risks, political, social and institutional risks are often covariate in nature.

8 Improvement in health or financial status is not just the result of higher incomes but is also an input into generating higher incomes, especially for the poor.

9 Both these problems arise due to informational asymmetry between seller and buyer of insurance. Generally, it is observed that the buyer of insurance is more well-informed about his health status and the care level taken by him. While adverse selection problem tends to reduce the size of membership, the moral hazard problem leads to over-consumption of benefits covered under the scheme.

10 This classification is only for the sake of simplicity. In reality one expects these factors to be interdependent. For example, weak supply of insurance services may be the result as well as the cause of poor demand. Similarly, if the design of insurance scheme is poor, it may fail to attract households.

11 This is not to deny the role of other demand side factors such as the social and cultural milieu in which the poor live, access to other risk management instruments and so on. To give an example of how social cultural factors pose a barrier to demand for insurance, in some societies people believe that to think about the consequences of one's ill-health or death is to wish oneself the same. Similarly, in some societies people interpret ill-health, death or accident as the wish of the Gods, linked it to one's fate, and hence refuse any medical treatment and turn to their religious head.

12 Demand for insurance, which is mandated by the providers of credit to the poor, needs to be distinguished from the demand for insurance necessitated purely by health considerations. In the former case, insurance protects the interest of the creditor against the risk of default in the event of the borrower falling ill. In the latter case insurance protects the financial interest of the borrower in the event of his/her falling ill. Furthermore, in the former case premium is deducted from the credit extended to a borrower, and in the latter case, timings and mode of premium collection are important determinants of demand for health insurance. In this section we analyse the latter case.

13 The poorest of the poor would not buy insurance even if some credit is made available to them. The needs of the excluded (the poorest of the poor) are often not structured in terms of "solvent demand."

14 According to Holzmann (2001) the group of poor that moves in and out of poverty is strikingly large compared to the group that is always poor (poor at all dates). In fact, one could further subdivide the poor who move in and out of the poverty, depending on their income prospects.

15 Allowing flexibility in paying premium is similar, in effect, to extending credit facility to the individual who buys insurance for the purpose of paying premium. The credit gets returned when the individual actually pays the premium amount.

16 In this context it is also important to recognise what public intervention should not do as some interventions may actually have a negative impact on the functioning of community financing schemes (Hsiao 2001).

A Macro Look at Micro Insurance

— The means, ways and methodologies

Low-premium and tailor-made policies for economically and socially backward rural regions, offered through proficient agencies, will take micro insurance to the farthest corners of the nation, writes *K.G.P.L. Ramadevi.*

India is currently standing at the crossroads. On the one hand, it is enjoying a remarkable period of economic growth in many sectors, substantial improvement in purchasing power, increasing brand consciousness, changing consumption patterns and rapid spread of the communication network offering vast business potential for the corporate sector. On the other hand, the nation is trying to cope with more than 300 million people living below the poverty line in rural/ backward areas, screaming for attention. If the nation expects to hit the high-growth trajectory in the years to come, it would do well to take heed of its hungry and financially insecure millions. A key aspect of upliftment of the poor is to provide them insurance.

Insurance for the poor was never considered a priority area, though it was obligatory for insurance companies to do a stipulated percentage of their business in the rural and social sectors. While initiatives were developed to fill the supply-demand gap for credit for the rural poor by a network of banks, little awareness was created for an insurance cover catering to the various needs of their life cycle.

Bridging the gap

As the traditional insurance industry has not been able to meet the requirements of the rural poor, and since the poor are not normally considered a priority area to provide appropriately designed insurance products, micro insurance can become an effective financial tool to fill the gap and address the problem effectively.

Micro insurance is a form of insurance, which offers limited protection for a low contribution (hence 'micro').

It is aimed at poor sections of the population and designed to help them cover themselves collectively against risks (hence 'insurance'). If properly developed on scientific lines, micro insurance can carry enormous potential for transforming the lives of the rural poor. It can be effectively linked to provide health insurance, accident insurance and social security for rural communities.

The formal institutions are unable to reach the poor and weaker sections of the rural areas due to factors such as low creditworthiness of the poor and high transaction costs. Other informal groups, such as NGOs/ service oriented organisations who have proximity to the rural poor due to their other associated activities, are in a better position to motivate the people to go in for insurance. They, therefore, form the right alternative channel to take up such activities. Sometimes, they work in remote areas where the existing insurers have limited access. As most of them are self-sustaining units, and have long standing relationships with members, chances of moral hazard are also much less.

> If properly developed, micro insurance can transform the lives of the rural poor. It can be effectively linked to provide health insurance, accident insurance and social security for rural communities.

Self-help groups (SHGs), NGOs, co-operatives or any other organisation, which has been playing an active role in empowering the rural poor, can be considered to carry out micro insurance activities. In order to tap the potential in the rural sectors and with a view to increase the penetration of insurance, such organisations can be assume the role of intermediary/corporate agents, or develop a new channel on the lines of the referral model to popularise micro insurance initiatives. Both these activities do not require any capital base.

There is also demand for allowing co-operatives to take up micro insurance as per the specific requirements of the targeted rural poor masses which, however, requires a minimum capital of Rs. 100 crore under the existing regulatory set up. Section 8A of Insurance Act (Amended) defines these as Insurance Co-operative Societies, thereby not preventing them to act as insurers.

A SWOT analysis

How would NGOs/SHGs/co-operative federations or similar institutions fare in micro insurance activities? A SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis may summarise it:

Strengths: These groups have close proximity to the rural poor due to their other activities and are in a better position to motivate them to go in for insurance. They often work in the remote areas of the country where the existing insurers have limited access. They need not incur any additional management expenses to step into the new business, since they already have a distribution network in place, which can be effectively utilised for canvassing the insurance business. As most of them are self-sustaining units, and have long standing relationship with their members, chances of moral hazard are also relatively lower.

Weaknesses: In case they are allowed to operate with a low capital base, the capacity of the organisations to absorb the losses can become inadequate. Underwriting of insurance requires a high degree of knowledge and technical skills, which the members of the co-operatives, most of them being illiterate, may not possess. Further, there is concentration of risk without any spread due to limited geographical operations, and the policyholders group being homogenous. This is against the

principles of insurance and in turn makes them vulnerable to losses in case of occurrence of even a single calamity (eg: Latur/Gujarat earthquake). Also, in the present competitive era, the groups may not be able to cope with demands such as aggressive marketing, innovative thinking, fast communication systems and effective management techniques which are essential for a successful insurance venture.

Opportunities: As the groups understand the requirements vis-à-vis payment capacity of the target group, effective and affordable premium products can be developed. They can also develop simple claim settlement mechanisms customised for the illiterate masses of rural India. This will effectively do away with procedural complexities including technical jargon in the policies/terms, conditions and exclusions. As they can effectively use their existing set-up to service the new insurance activities, the management expenses are restricted to the minimum.

Threats: Though the groups have been successfully carving a niche in taking up micro finance activities, the insurance business is quite different. In the mainstream financial services, the primary business is lending small amounts to the poor and recovering the same by pooling the savings of members. There is an obligation on the members to repay the loan – otherwise they cannot take fresh loans. Insurance principles are different and highly technical and require management skills to safeguard the interests of the policyholders. Unless given adequate training in the area, the SHGs/NGOs would not know much about insurance, where they have to part with a portion of their little savings in anticipation of a future loss. Further, if the insurer fails to fulfil its obligations towards the policyholders, it will be highly difficult for the policyholders to mitigate the crisis and, ultimately, they will lose confidence in the insurance system.

Despite these shortcomings, in order to meet the demands and requirements of the rural poor, micro insurance can become an effective tool to provide insurance coverage to low income individuals or groups that are adversely affected by a specific risk or event. Since the existing Insurance Act and IRDA regulations are rather silent on the issue and there is no bar/limitation in this regard, various factors required for the successful running of such a system have to be evaluated. Also, similar experiments in other parts of the world should be studied carefully before finalising a suitable micro insurance set-up for India.

Global trends

A worldwide study would reveal that micro insurance is mostly offered by micro finance institutions (MFIs) as part of their services. It is due to the fact that the insurance can reduce the risk and increase the effectiveness of credit saving activities. This enables the micro financers to penetrate deeper into the market.

SHGs, NGOs or cooperatives, which have been playing an active role in empowering the rural poor, can be considered to carry out micro insurance activities.

It is interesting to observe that there is a social angle as well as a commercial one in the spread of micro insurance by MFIs. On the social front, insurance reduces the impact of individual household losses that could exacerbate their poverty situation. On the commercial front, it reduces the impact of defaults on loan risks and improves the community's savings portfolio. In other words, insurance not only plays a vital role in mitigating vulnerability to economic losses but also enhances the stability and financial situation of individual households.

Governments across the world, including in The Philippines, Indonesia, Cambodia and some of the African countries, have identified insurance as a social security measure and taken up micro insurance. Such programmes are either directly sponsored by government/ donors or managed by the members of the groups themselves. In our neighbouring countries Bangladesh and Nepal, it is the NGOs and SHGs who are the torchbearers for the movement.

Bangladesh: The pioneer of the micro finance model, Grameen Bank, and Delta Life Insurance have successfully established themselves in offering insurance coverage to their members. Besides, many NGOs that have started offering micro credit are also extending health coverage without charging any extra premium.

Nepal: In Nepal, innovative health micro insurance schemes have been developed to provide healthcare for the poor and excluded populations. The Lalitpur Medical Insurance Scheme, one of the oldest forms of micro insurance in the country, has established 'local health posts' under the Community Health Development Programme of the United Missions to Nepal. It mainly covers the costs of essential drugs and a range of promotional and preventive healthcare at nominal fee. Another major social health insurance scheme at the B. P. Koirala Institute of Health Sciences covers around 18,000 members, from both the formal and informal economy.

Besides, there are other community-based healthcare services offered to the poor, such as the Public Health Concern Trust. The society, formed by a group of doctors, has created health co-operatives with the involvement of local communities to offer health micro insurance to community members through local clinics. These schemes help pool risks and resources of community groups to provide health protection to all members against the financial consequences of various risks. Encouraged by the success of such schemes, the Nepal Government, in association with the International Labour Organisation, has been actively fostering their development.

The scenario back home

The Indian Government has constituted a "Consultative Group on Micro Insurance" to study the feasibility of extending insurance coverage as a measure of protection against the risks to the assets, lives and health of the poor in the context of overall social security. There is a need to re-look into the provisions of the Insurance Act/ IRDA

Regulations to promote new alternative delivery systems that are ready to take up micro insurance business, as there is a wide gap for them to meet the requirements of registration to carry on insurance business within the existing legal framework. The IRDA is already in the process of framing the required regulations. This will particularly help small /marginal farmers, landless labourers, etc.

If necessary, the existing legal framework should be reworked and amended suitably so that all the segments of population can be effectively brought under the umbrella of insurance, which will not only enhance the penetration levels of insurance but also significantly improve the standard of living for the people in the rural and social sectors.

There are certain sources of concern in allowing these alternative channels to take up micro insurance business in India. These include:

Capital requirements: Capital requirement is an important component of solvency. However, it is not the only component and the level of solvency is not exclusively guaranteed by the level of capital. The amount of capital for a new organisation should be adequate to make it a viable and solvent organisation, to meet its reserve fund requirements for the initial years. Hence, the minimum paid-up capital requirement of Rs. 100 crore can be relaxed for MIOs. If needed, the term deposit receipts of the members/ promoters in lieu of shortfall of the capital requirement can be considered. This can be pledged with any nationalised bank for a minimum period or till reaching the minimum capital requirements. Alternatively, risk based capital can be introduced based on actuarial assumptions, to begin with on a trial basis.

Section 94 A of the Insurance Act, 1938 does speak of exemption from certain provisions of the Act in favour of insurance cooperative societies. However, such exemptions from important provisions of law should not be allowed to hamper company in keeping its commitment towards the policyholders as well as investors.

Essential criteria: The company should have enough solvency for its smooth functioning, particularly in fulfilling its obligations towards policyholders. The following criteria may be considered before allowing such organisations for operations:

a) a demonstrated track record of running successfully at least for five years

b) promoted and managed by experienced professionals with relevant backgrounds

c) should have achieved minimum outreach (to be stipulated) or demonstrate the capability to reach this scale

d) should maintain a satisfactory and transparent accounting, MIS and internal audit system

On the flip side, there is concentration of risk without any spread due to limited geographical operations and the policyholders group being homogenous.

e) should have excellent performance rating / capacity assessment rating, which may be obtained from reputed agencies

Eligibility criteria: The types of organisations that can be considered as eligible for doing micro insurance business may be:

i) Societies registered under Societies Act, 1860 or similar Acts

ii) Trusts registered under Public Trusts Act, 1920 or similar Acts

iii) Companies registered under the Companies Act, 1956

iv) Non-banking finance corporations providing financial and insurance services to the poor

v) Specialised and other co-operatives such as mutually aided co-operative societies

vi) Any other type of institution that offers exclusive micro insurance service may be considered on merit

Various parameters, both qualitative and quantitative, should be defined before formulating appropriate regulatory framework for micro insurance. After registration, periodical evaluations reports should be obtained to assess the organisation's risk absorption capacity, solvency margin etc.

An opportunity-filled market

Rural markets do hold tremendous potential for growth of insurance business, particularly because of their strong saving habits. This is underscored by the finding that even the relatively low-income families tend to save about a third of their annual earnings. Building credibility is another key factor. First of all, awareness has to be created regarding the need to purchase an insurance cover by designing customised insurance products in simple language (regional languages can be used for effective communication).

It is important to have a larger number of people in the insurance coverage net, which will make it a more viable proposition. In this attempt, the available alternative channels of distribution can be explored, which are ready to accept the responsibility of taking insurance to the masses.

Towards achieving that goal, there is a need to link up and utilise the services of all the informal channels, which have been proven successful in touching the lives of the rural, economically backward, and poor masses of the country. Besides offering financial potential, micro insurance is also an important tool to ensure protection in the fight against poverty and social exclusion. If developed systematically on scientific lines, it can emerge as a powerful engine of social transformation by providing social security to the rural and backward sectors and indirectly will pave the way for effective penetration of insurance to the grass root levels.

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

प्रकाशक का संदेश

बीमा में निजी क्षेत्र को आज्ञा देने का प्राथमिक उद्देश्य बीमा आवरण को विस्तृत विस्तार देना था। बीमा की विस्तारशीलता प्राथमिक लक्ष्य था साथ ही निति निर्धारकों को यह भी ज्ञात था कि यह भी तथ्य है कि केवल वृद्धि ही समानता को सुनिशचित नहीं कर सकती। यह माया अर्थव्यवस्था के अन्य क्षेत्रों में भी कार्य नहीं कर सकी है तथा कोई ऐसा कारण नहीं है कि यह बीमा के मामले में कार्य करेगी। बीमा अधिनियम तथा उसके अर्न्तगत बनाये गये विनियम, यह निर्धारित करते हैं कि जारी कि गई पालसियों का एक निशचित प्रतिशत अनन्य रूप से जनसंख्या के कमजोर वर्ग के लिए रखा जाए।

आईआरडीए द्वारा तैयार किये गये सूक्ष्म बीमा विनियमों के मसौदा उस तंत्र को सुविधा प्रदान करता है जिससे विनियमन में रेखांकित सामाजिक उद्देशयों को प्राप्त किया जा सके। यह तंत्र मुख्य रूप से उस सूक्ष्म ऋण व्यवस्था पर तैयार किये गये है जो पहले से ही देश में विद्यमान है। प्राधिकरण को इस बात की भी जानकारी है कि देश के विभिन्न भागों मे अनौपचारिक रूप से सूक्ष्म बीमा ने पैर फैलाये हैं और यह विनियमन न केवल उन्हें वैधानिक संस्वीकृती देगें वरन प्रैक्टिस करने वालों को उत्तरदायित्व बनाया जा सकेगा। यह अंक विस्तृत रूप से सूक्ष्म बीमा से संबधित मामलों को सम्मलित किये हुए है। मसौदा विनियमन हमारी वेब साईट पर हैं तथा हमें राष्ट्रीय तथा अंतर्राष्ट्रीय संस्थाओं से सुझाव मिले हैं। हमें इस सलाहकार प्रक्रिया से लाभ मिला है तथा हमने जहाँ कहीं भी आवश्यक हुआ विनियमों में सुधार किया है।

इस अंक में हमने वर्ष २००४-०५ के वार्षिक व्यवसायिक आंकड़ों को शामिल किया है। हमने जीवन तथा गैर जीवन दोनों क्षेत्रों में ढांग वृद्धि दर्ज की है । उल्लेखनीय विशेषता निजी कंपनियों कि अच्छा कार्यनिष्पादन रहा जिन्होने अपने बाजार अंश को जीवन बीमा क्षेत्र में पहले वर्ष के प्रिमियम का पाचॅवें भाग तक तथा साधारण बीमा के कुल प्रिमियम में वृद्धि दर्ज की गई।

अगले अंक में हम यह परीक्षा प्रस्तावित करते हैं कि बीमा संविदा में प्रयोग की जाने वाली भाषा का सरलीकरण कैसे किया जाए जिससे बीमाकर्त्ता इसे आसानी से समझ सकें। पारंपरिक रूप से बीमा संविदा की भाषा कुछ विशेषाधिकार प्राप्त लोगों को ही समझ आती है ! सरल भाषा अभियान को लक्ष्य बनाया जाए शब्दों के प्रचलित भाषा में अनुवाद के साथ अपने अधिकार तथा कर्तव्य का ज्ञान आम आदमी को सशक्त करेगा और बीमा उद्योग के लिए उपयुक्त होगा। विदेशों में इसने जागृति पैदा की हैं तथा बीमा कंपनियों के बीच यह सबसे प्रचलित ग्राहक सेवा पद्धति है। हम यह देखगे कि अंतर्राष्ट्रीय रूप से क्या प्राप्त किया जा सका है तथा भारत में अंग्रजी के सरलीकरण के लिए क्या किया जा सकता है।

सी. एस. राव

सी. एस. राव

“ कुछ तो लोग कहेंगे ”

लाभ सहित उत्पाद साधारण नहीं हैं इन्हें समझना असान नही है। वैसे निर्विघ्न निवेश उत्पादों की संकल्पना अपेक्षाकृत स्पष्ट है, व्यवहार में यह कैसे परीचालित होती है पॉलसीधारक के लिए इसकी व्यापकता जानना कठिन है।

श्री डेविड स्टेचहन, बीमा क्षेत्र के नेता, वित्तिय सेवा प्राधिकरण, यू. के.

(प्राधिकरण को जरूरत है) संतुलन बनाने की, प्रभावशाली प्रूडेंशल पर्यवेक्षण तथा अति विनियमन के मध्य

श्री जान लेकर, अध्यक्ष, आस्ट्रेलिया प्रूडेंशल विनियामक प्राधिकरण (एपीआरए)

मेरा त्यागपत्र का निर्णय मेरी उस अक्षमता का परिणाम है जिसमें कंपनी के तथा उसके प्रचलन के बारे में सूचना नहीं प्राप्त कर सका जिससे मेरी वैश्वासिक कर्तव्य पूरे हो सके।

श्री मौरिस आर. ग्रीनबर्ग अमेरिकन इंटरनैशनल ग्रुप के निदेशक मंडल से अपने त्यागपत्र देते हुए। जिसे उन्होने चार दशकों तक निभाया।

हम सनमार के लिए नया साझेदार ढूँढ लेगें अथवा पूरा व्यवसाय बेच देगें अथवा दूसरे निवेशकों की तरफ भी देख सकते हैं।

श्री ग्राहम मेयर, प्रबन्ध निदेशक, एएमपी सनमार लाईफ इंशूरेंस

देश में बीमा की प्रतिष्ठा के लिए एक पक्ष का अस्तित्व एकल नहीं है। 35 प्रतिशत से 15 प्रतिशत की वृद्धि बाजार शक्ति का साक्ष्य-सत्यापन है।

श्री सी. एस. राव अध्यक्ष आईआरडीए

हर स्तर पर, कंपनी को अपनी कार्य योजना के बारे में हमें सूचित करना होगा। हम ऐसी स्थिति को पसंद नहीं करते जहाँ बाद में साझेदार की शिनाख्त बाद में की जाए, हमें पता चले की साझेदार दिशा-निर्देश को पूरा नहीं करते।

श्री सी. एस. राव अध्यक्ष आईआरडीए

समय में पिरोना...

-बीमाकर्ता को सबसे पहले ग्राहकों की जिज्ञासाओं का समाधान करना चाहिए।

ग्राहकों को पॉलिसी की टर्म्स की पूर्ण जानकारी देने तथा सेटलमेंट के समय सही व्यवहार करने से ग्राहक ओम्बड्समेन एवं कोर्ट से दूर रहेगा। कहते हैं, ***यघ्नप्रिया भरत***

परिचय अंश 1: ग्राहकों की यह शिकायत आम रहती है कि बीमाकर्ता ने उत्पाद बेचने के समय तो बहुत उत्सुकता दिखाई किन्तु जब सेटलमेंट का समय आया तो सारी उत्सुकता धरी की धरी रह गई।

परिचय अंश २: बीमाकर्ता बीमा उत्पाद बेचते समय पूर्ण पारदर्शिता क्यों नहीं रखता है तथा सही तरीके से इसका विवरण भी नहीं करता है।

बीमाकर्ता की पूरी साख क्लेम के निपटारे के समय ही सामने आती है। इस समय ग्राहक बीमा कंपनी से पूर्ण सहयोग की अपेक्षा रखता है, क्योंकि एजेंट द्वारा भी ग्राहक को प्रारंभ में यह बताया गया था कि क्लेम का निपटारा आसानी से हो जाएगा तथा हम बहुत ही आसान प्रक्रिया अपनाते हैं। परन्तु यदि क्लेम के निपटारे के वक्त बीमा कंपनी ने थोड़ी सी भी लापरवाही बरती तो ग्राहक स्वयं को ठगा सा महसूस करता है, क्योंकि उसने अपना पैसा लगाया है, और उसे अपने पैसे की पूरी कीमत चाहिए।

गैर जीवन बीमा कंपनियों से संबंधित 2000 से अधिक लिखित शिकायतें तथा 1500 से अधिक फोन कॉल्स प्राप्त हुए हैं। हम आईआरडीए में ग्राहकों की शिकायतों का निपटारा करते हैं तथा हम यह समझते हैं कि क्लेम के निपटारे के वक्त एक ग्राहक की क्या अपेक्षा रहती है। सभी ग्राहक लगभग यही कहते हैं कि बीमा बेचते समय तो बीमा कंपनी ने काफी उत्सुकता दिखाई, परन्तु जब क्लेम के निपटारे का समय आया तो सारी उत्सुकता धरी की धरी रह गई।

मैं जो यहाँ लिख रही हूँ, वो शिकायत निपटारा अधिकारी के रुप में मेरे स्वयं के अनुभव हैं। यह ध्यान रखने योग्य बात है कि मैनें जो ऊपर शिकायतों के बारे में लिखा है, वो प्राप्त शिकायतों का एक भाग मात्र है। बीमा उद्योग इससे कहीं अधिक शिकायतें रखता है। ग्राहक के पास अपनी

> हमें कई शिकायतें ऐसी मिली है जहाँ ग्राहकों को शर्तों एवं नियम की पूर्ण जानकारी नहीं दी गई थी। ऐसी शिकायतें काफी मात्रा में मिलती है। ग्राहकों के क्लेम का निपटारा नहीं किया जाता है।

शिकायतें दर्ज कराने के लिए कई चैनल्स हैं, जिनमें आईआरडीए का शिकायत निपटारा प्रकोष्ठ, ओम्बड्समेन, उपभोक्ता अदालत तथा अन्य ज्यूडिसियल चैनल्स हैं।

यदि एक शिकायतकर्ता बाहरी स्त्रोतों से याचना करता है (बीमाकर्ता के अलावा) तो यह इस तथ्य को इंगित करता है कि उस व्यक्ति को बीमा कंपनी में अब कोई विश्वास नहीं रह गया है या फिर उसे वहाँ से कोई उत्तरदायी जवाब नहीं मिला है, शिकायत का निपटारा तो दूर की बात है। कई बार ऐसा भी होता है कि जब तक बाहर शिकायत न की जाए, बीमाकर्ता ग्राहक की समस्या को समस्या ही नहीं समझता है। बीमाकर्ता के लिए यह आवश्यक है कि शिकायतों के निपटारे के लिए एक प्रकोष्ठ का निर्माण किया जाए तथा इसके प्रक्रिया की जानकारी ग्राहकों को दी जाए।

तार्किक स्पष्टीकरण

प्राय: सभी शिकायतों को पढ़ने से हमें इस बात का पता चलता है कि ग्राहक यह जानना चाहते हैं कि उनके क्लेम को लेकर एक विशेष निर्णय क्यों लिया गया है, चाहे यह क्लेम की उपेक्षा करना हो या फिर दिए जाने वाले क्लेम में कटौती। कई लोग नहीं जानते की बीमा क्षेत्र में किस प्रकार से कार्य होता है जैसे की वारंटी, शर्तें एवं नियम क्या क्या हैं? यह जरुरी है कि बीमा बेचते समय ग्राहकों को सभी तथ्यों की पूर्ण एवं सही जानकारी प्रदान की जाए। पारदर्शिता लाकर ही ग्राहकों का विश्वास जीता जा सकता है।

हमें कई शिकायतें ऐसी मिली है जहाँ ग्राहकों को शर्तों एवं नियम की पूर्ण जानकारी नहीं दी गई थी। ऐसी शिकायतें काफी मात्रा में मिलती है। ग्राहकों के क्लेम का निपटारा नहीं किया जाता है।

कई बार क्लेम में कटौती भी की जाती है। ग्राहक के पास वाद-विवाद करने के लिए इतना समय नहीं होता है तथा साथ ही उनके पास क्षमता भी नहीं होती है। मैनें एक आदमी को देखा जिसने उसकी मेडीक्लेम पॉलिसी के क्लेम में से ४९ रुपये

काटे जाने पर कड़ी आपत्ति प्रकट की। उसे ४९ रुपये काटे जाने की इतनी चिंता नहीं थी, उसे आपत्ति इस बात से थी की बीमा कंपनियों के कर्मचारियों द्वारा यह कहा गया कि तुम्हें कम से कम बाकी रुपये तो मिल गए, तुम्हें इससे खुश होना चाहिए। उस आदमी ने अपना काफी समय लगाया और अंत में उसकी जीत हुई।

अंडरराइटिंग पर दोष लगाना

गलत अंडरराइटिंग की भी काफी शिकायतें आ रही हैं। अंडरराइटिंग में गलती माने बिना वे लोग पॉलिसी की वर्डिंग्स के अनुसार ही प्रक्रिया अपनाते हैं। ऐसी भी शिकायत प्राप्त हुई है। इस शिकायतकर्ता को तेज बुखार हुआ था, परन्तु मेडीक्लेम पॉलिसी होने के बावजूद उसे अस्पताल का खर्च देने से मना कर दिया गया क्योंकि उसने अपने प्रोपोजल फॉर्म में यह उल्लेख कर दिया था कि एक बार उसे तेज बुखार एवं डिहाइडेशन के लिए एक सप्ताह के लिए अस्पताल में भर्ती किया गया था। ऐसी शिकायतें उन लोगों को सिग्नल प्रदान करती है जो पॉलिसी लेने वाले हैं तथा फिर वे अपने कुछ जरुरी तथ्य प्रोपोजल फॉर्म में छिपाने लगते हैं।

खासकर कई ग्राहकों को यह जानकारी नहीं होती है कि उनकी पॉलिसी गलत हो सकती है, यदि वे कुछ आवश्यक तथ्यों को छिपाते हैं या छिपाने की कोशिश करते हैं। फिर जब उनका क्लेम नहीं दिया जाता है, तो वे स्वयं को ठगा सा महसूस करने लगते हैं। इसलिए ग्राहकों को बीमा बेचते समय ही इसके सभी नियमों एवं शर्तों के बारे में बता देना चाहिए। यदि ऐसा किया गया तो शिकायतों की संख्या आधी हो जाएगी।

संभावित: प्रमुख शिकायत यह रहती है कि ग्राहकों को क्लेम के समय सही तरीके से गाइड नहीं किया गया या उनकी बात नहीं सुनी गई। बीमा कंपनियों को इस बात पर विशेष ध्यान देना चाहिए कि शिकायत निवारण सिस्टम ग्राहकों के समक्ष हो ताकि उन्हें पता चले कि कहाँ शिकायत करनी है। आईआरडीए का शिकायत निवारण प्रकोष्ठ, बीमा ओम्बड्समेन, उपभोक्ता अदालत तथा अन्य ज्यूडिसियल संस्थाएँ ग्राहकों की शिकायतों का निपटारा करते हैं तथा साथ ही बीमा कंपनियों को यह बताते हैं कि उनके उत्पादों में क्या क्या खामियाँ हैं।

लेखिका आईआरडीए में उप निदेशक के पद पर कार्यरत है तथा उपरोक्त विचार उनके स्वयं के हैं।

कल आज और कल

गिनती के लिए खडे हो जाए

- बीमा उध्योग की स्वविनियमन यात्रा

के. नित्य कल्याणी

एक पूर्ण विश्व में स्व-विनियमन की काफी आवश्यकता है। परंतु वास्तविक जीवन और वह दबाव जिसके साथ भारतीय बाजार में कार्य करना पड़ता है, स्व विनियमन उत्तरदायी उद्योग की केवल कुछ जरुरतों को ही पूरा कर सकता है तथा इससे अधिक एक साथ मिलकर काम करने के लिए उपयोग में लाया जा सकता है। स्व विनियमन एक ऐसा जरिया है जो वास्तविक रुप से उद्योग संबंधी सभी समस्याओं को समाधान कर सकता है।

स्व विनियमन कोई नया या बाहर से आया हुआ विचार नहीं है। विभिन्न उद्योगों एवं पेशेवरों द्वारा इसे अपनाया गया है ताकि ग्राहकों का विश्वास हासिल किया जा सके। पिछले कुछ वर्षों से बीमा उद्योग ने भी स्व विनियमन को अपनाया है तथा इसके पश्चात इसमें काफी विकास हुआ है।

जब हम स्व विनियमन की बात करते हैं तो एक अन्य बात हमारे सामने आती है और वह यह है कि इसे अकेले संचालित नहीं किया जा सकता है, इसके लिए एक केन्द्रीय प्राधिकरण चाहिए तथा साथ ही बाहरी ऑडिट की भी इसे आवश्यकता पड़ती है।

श्रीमति शिखा शर्मा, *सीईओ, आईसीआईसीआई प्रुडेन्सियल लाइफ इंश्योरेंस कंपनी*

बीमा काउंसिल जो स्व विनियमित संगठन है सक्रिय हो रहा है। आपके अनुभव में, यह कहाँ तक कार्य कर रहा है?

मैं यह कहुँगी कि यह कार्य कर रहा है। शुरुआत में कुछ दिक्कतें आती है। पहली बात है स्व विनियमित मॉडल एवं आईआरडीए की एक विनियामक के रुप में उपस्थिति। पर आईआरडीए काउंसिल के साथ भागीदार है। दूसरी बात यह है कि मिस्टर मॉनीकी महासचिव के रुप में बोर्ड में उपस्थिति। वे एक अच्छे आदमी हैं जो अपने कार्यों के बारे में हर समय सोचते रहते हैं। मिस्टर बनर्जी (सदस्य-जीवन, आईआरडीए) अब एक पर्यवेक्षक हैं तथा ये देखते हैं कि काउंसिल स्वतंत्रता पूर्वक अपना कार्य करे।

किन क्षेत्रों में आपने स्व विनियमन को प्रभावी पाया है? क्या आप इसके लिए कारण बता सकते हैं?

स्व विनियमन तभी कार्य कर सकता है जब सभी लोग इसमें रुचि लें। यदि लोगों में इसको लेकर विरोधाभास होगा तथा सदस्य परस्पर सहयोग नहीं करेंगें तो इसका टिकना संभव न होगा। इसके लिए काउंसिल एक साझा न्यूनतम कार्यक्रम तैयार कर सकती है।

भविष्य में किन क्षेत्रों में स्व विनियमन प्रभावी रह पाएगा?

मैं सोचती हूँ कि हमें उन सभी जगह मिलजुल कर काम करना चाहिए जहाँ विनियमन संरचना एवं कर संरचना में परिवर्तन की जरुरत है। कई चीजे हैं जो एक एसआरओ कर सकती है। ग्राहकों के मामले में वे स्व विनियमन कर सकती है तथा कुछ लोगों ने इस तरफ कदम बढ़ाए हैं।

वित्तीय सेक्टर में पश्चिमी देश स्व विनियमन से पीछे हट रहे हैं। पर भारत में इसके लिए इतना हल्ला क्यों है?

भारत में पर्याप्त विनियमन है। विनियमन का स्तर काफी ऊँचा है तथा मैं नहीं समझती की विनियामक के पावर में इससे कोई कमी होगी। चुँकि यह पूरी तरह से कसा हुआ विनियमन बाजार है, यह तथ्य हमारे बाजार में संचालित नहीं होता है।

श्री वेंकटेश मैसूर, *सीईओ, मेटलाइफ इंडिया*

बीमा काउंसिल जो स्व विनियमित संगठन है सक्रिय हो रहा है। आपके अनुभव में, यह कहाँ तक कार्य कर रहा है?

मैं नहीं सोचता कि कुछ खास हुआ है। इसके बारे में बातें हो रही है। काउंसिल से कोई भी विनियमन नहीं आया है। इसकी काफी संभावनाएँ हैं, परन्तु अभी इसमें समय लगेगा।

किन क्षेत्रों में आपने स्व विनियमन को प्रभावी पाया है? क्या आप इसके लिए कारण बता सकते हैं?

मैनें एक फॉर्मेट तैयार किया है जो यह सुनिश्चित करने में मदद करेगा कि हम उद्योग एवं ग्राहकों के साथ इसे किस प्रकार लागु कर सकते हैं। हमने स्व विनियमन को अभी तक प्रारंभ नहीं किया है।

भविष्य में किन क्षेत्रों में स्व विनियमन प्रभावी रह पाएगा?

एजेंट लाइसेंसिंग पर यह अच्छी तरह कार्य कर सकता है। आजकल यह क्षेत्र नो-विन रह

गया है। 100 घंटे का प्रशिक्षण, परीक्षा इत्यादि आईआरडीए ने लागु किया है। उद्योग भर्ती कर रहा है, इसके पीछे प्रयास अच्छा हो सकता है पर इसे लागु किए जाने में समस्याएँ आ रही है। जब बराबर स्व विनियमन हो तो आईआरडीए को केवल टेस्ट से मतलब होना चाहिए न कि प्रशिक्षण के घंटों से। तब बीमा कंपनियाँ योग्य लोगों को इसके लिए तैयार कर सकेगी तथा उन्हें टेस्ट लिखने का मौका दिया जा सकेगा।

आईआरडीए स्व विनियमन पर इतना जोर नहीं दे रहा है तथा वे लोग समझते हैं कि उन्हें सिर्फ ग्राहकों के हितों का ही ध्यान रखना है।

बीमा कंपनियों के हित में यही है कि वे योग्य उम्मीदवारों को प्रशिक्षण प्रदान करे ताकि स्व विनियमन अपने आप आ जाएगा। मैं चाहुँगा की मेरे एजेन्ट योग्य हों ताकि हम अच्छा बिजनेस कर सकें। मैं आईआरडीए को सलाह दूँगा कि वे ये सभी बातें उद्योग एवं बीमा कंपनियों पर छोड़ दे तथा केवल टेस्ट की गुणवत्ता पर अपना ध्यान केन्द्रित करे।

प्रशिक्षण के दौरान भी उत्पाद पर ज्यादा ध्यान देना चाहिए। उदाहरण के लिए यूनिट लिंक्ड उत्पादों के लिए अलग से प्रशिक्षण एवं टेस्ट होना चाहिए।

वित्तीय सेक्टर में पश्चिमी देश स्व विनियमन से पीछे हट रहे हैं। पर भारत में इसके लिए इतना हल्ला क्यों है?

उदाहरण के लिए ब्रिटेन में विनियमन में काफी परिवर्तन आया है। हमें यह देखना है कि उद्योग में अभी क्या हो रहा है।

श्री मैथ्यू वर्गिस, *सदस्य, गैर-जीवन, आईआरडीए*

बीमा काउंसिल जो स्व विनियमित संगठन है सक्रिय हो रहा है। आपके अनुभव में, यह कहाँ तक कार्य कर रहा है?

मैं यह नहीं समझता की एसआरओ मॉडल सफलता पूर्वक कार्य कर सकेगा। सही एसआरओ का होना काफी मुश्किल है क्योंकि कंपनियाँ अपने बिजनेस की तरफ ज्यादा ध्यान देती है। परन्तु, अन्य देशों के उदाहरण देखते हुए मैं कहुँगा कि यदि सीईओ इस बारे में रुचि लें, तो इसे सफल बनाया जा सकता है।

किन क्षेत्रों में आपने स्व विनियमन को प्रभावी पाया है? क्या आप इसके लिए कारण बता सकते हैं?

विकास काफी धीमा है। वार रिस्क प्रीमियम जो कि मैरिन हल बिजनेस के लिए है, जनरल इंश्योरेंस काउंसिल ने मामले की शुरुआत की है तथा निजी कंपनियों को इसे कलेक्ट करने की इजाजत मिलनी चाहिए। यह मामला हाँलाकि सरकार द्वारा वार रिस्क कवर प्रदान करने के साथ ही तय हो गया तथा यह कंपनियों पर छोड़ दिया गया कि वे जैसा सही समझे करें।

भविष्य में किन क्षेत्रों में स्व विनियमन प्रभावी रह पाएगा?

कई ऐसे तकनीकि क्षेत्र हैं जहाँ काउंसिल एसआरओ की भूमिका अदा कर सकती है। उदाहरण के लिए क्लेम्स के निपटारे में मानदंड निर्धारित करना या फिर अंडरराइटिंग अनुशासन।

यह डिटैरिफिंग के लिए शुरुआत कर सकता है तथा किलेम्स अनुभव डाटाबेस को ला सकता है- चाय भाड़ा के निरस्तीकरण के समय उन्होंने इसी प्रकार कार्य किया था। अब हम यह चाहेंगें कि फायर पॉलिसीज पर कुछ जोखिम का डिटैरिफिंग हो ताकि हम इसके लिए कार्य कर सकें।

वित्तीय सेक्टर में पश्चिमी देश स्व विनियमन से पीछे हट रहे हैं। पर भारत में इसके लिए इतना हल्ला क्यों है?

पश्चिमी देशों में कई जगह स्व विनियमित बॉडी हैं जहाँ बाजार के सभी भागीदार सदस्य हैं। विनियामक अपना उत्तरदायित्व एसआरओ को देता है, यदि यह कार्य करे, और यदि यह कार्य नहीं कर सकता है तो यह अपने उत्तरदायित्व को पुन: ले सकता है।

श्री अरुण अग्रवाल, *सीईओ, चोलामंडलम एमएस जनरल इंश्योरेंस कंपनी*

बीमा काउंसिल जो स्व विनियमित संगठन है सक्रिय हो रहा है। आपके अनुभव में, यह कहाँ तक कार्य कर रहा है?

हमें अभी इस दिशा में काम करना है। तथ्य पर बातचीत जारी है, इसे मान लिया गया है। काउंसिल का एसआरआई में बदला जाना भी मान लिया गया है। यह भी निर्णय लिया गया है कि मुम्बई में हमारा एक सचिवालय होगा। संविधान के निर्माण एवं वैद्य मुद्दों पर भी हमारी बातचीत हुई है तथा साथ ही महासचिव को किस प्रकार चयन किया जाए, इस पर भी बात हुई है। पर यह कार्य काफी धीमा हो रहा है। सभी कंपनियों को एक साथ इसके लिए काम करना होगा तथा वो भी एक नियत समय में।

किन क्षेत्रों में आपने स्व विनियमन को प्रभावी पाया है? क्या आप इसके लिए कारण बता सकते हैं?

टैरिफ एवं रिबैटिंग के मामले में इसे लागु किया जा सकता है। हम बैंचमार्क दरों जो कि वार रिस्कस एवं एसआरसीसी के लिए है, पर कार्य कर सकते हैं। उद्योग स्तर पर पारदर्शिता की आवश्यकता होगी। टैरिफ एवं डिटैरिफिंग, मध्यस्थ ये ऐसे क्षेत्र हैं, जहाँ एसआरओ प्रभावी हो सकता है। सोलाटियम फंड एवं टेररिज्म पूल अच्छा कार्य कर रहे हैं।

भविष्य में किन क्षेत्रों में स्व विनियमन प्रभावी रह पाएगा?

रोडमेप तैयार किया जा चुका है तथा हम इसके लिए पूरी तरह से कार्य कर रहे हैं। बाजार संचालन एवं बाजार से संभावनाएं ऐसे क्षेत्र हैं, जहाँ स्व विनियमन को लागु किया जा सकता है।

वित्तीय सेक्टर में पश्चिमी देश स्व विनियमन से पीछे हट रहे हैं। पर भारत में इसके लिए इतना हल्ला क्यों है?

मैं इस बारे में ज्यादा नहीं जानता। पर चुँकि बाजार आगे बढ़ रहा है, हमें एक साझा प्लेटफॉर्म तैयार करना होगा ताकि हम साथ साथ रह सकें।

श्री एस. वी. सामंत, *सीईओ, एचडीएफसी छब्ब जनरल इंश्योरेंस कंपनी*

बीमा काउंसिल जो स्व विनियमित संगठन है सक्रिय हो रहा है। आपके अनुभव में, यह कहाँ तक कार्य कर रहा है?

जनरल इंश्योरेंस में स्व विनियमन अभी तक लागु नहीं हुआ है। हमने केवल सामान्य तिमाही बैठकें आयोजित की है। पहली बात हमें एक फूल टाईम महासचिव की आवश्यकता है तथा हम इसके लिए मसौदा तैयार कर रहे हैं, साथ ही एक सचिवालय की भी स्थापना की जानी है।

किन क्षेत्रों में आपने स्व विनियमन को प्रभावी पाया है? क्या आप इसके लिए कारण बता सकते हैं?

यह अभी तक प्रभावी नहीं हो पाया है क्योंकि एसआरओ के उत्तरदायित्व के लिए अभी किसी प्रकार के संविधान का निर्माण नहीं हुआ है। इसके लिए काउंसिल चैयरमेन आईआरडीए से नहीं होना चाहिए, क्योंकि उनकी उपस्थिति में सदस्य सही तरीके से मुद्दे पर बात नहीं कर पाएँगें।

भविष्य में किन क्षेत्रों में स्व शिनियमन प्रभावी रह पाएगा?

कोड ऑफ कंडक्ट एक ऐसा ही क्षेत्र है। काउंसिल टैरिफ एवं डिटैरिफिंग के लिए एक सलाहकार की भूमिका अदा कर सकती है तथा विनियमन प्रक्रिया के लिए यह आईआरडीए की एक सदस्य संस्था के रुप में कार्य कर सकती है।

नए नियमें एवं मानदंडों को निर्धारित करने की दिशा में यह कार्य कर सकती है। यह सलाह दे सकती है तथा उन पर अध्ययन भी कर सकती है। यह विभिन्न पूल्स जैसे टेररिज्म पूल पर कार्य कर सकती है। अभी तक इस दिशा में कोई भी अच्छा कार्य नहीं हुआ है।

वित्तीय सेक्टर में पश्चिमी देश स्व विनियमन से पीछे हट रहे हैं। पर भारत में इसके लिए इतना हल्ला क्यों है?

अभी हम शुरुआती दौर में हैं। उद्योग के विकास के लिए यह जरुरी है कि हम अपने उत्तरदायित्वों को सही बँटवारा करें। पश्चिमी देशों में उद्योग काफी विकसित हो चुका है। मुख्य बात यह है कि विनियामक की भूमिका क्या है? पश्चिमी देशओं में शेयरधारकों, पॉलिसीधारकों एवं सरकार के हित की दिशा में प्रबंधन किया जा रहा है। हमें इन्हें लागु करना है।

अनुरूप टोनी सिहँ - *उपअध्यक्ष, मैक्स न्यूयार्क लाईफ इंशूरेस कंपनी*

बीमा काउंसिल जो स्वंय विनियमित संगठन हैं वह सक्रिय हो रहा है। आपके अनुभव के अनुसार यह अवधारणा किस प्रकार काम कर रही है ?

जीवन बीमा काउंसिल ने अच्छी शुरूवात की है। काउंसिल स्तर पर हम मुद्धों की शिनाख्त करने में समर्थ रहे हैं। ऐसा कहते हुए उल्लेखनीय कार्य पूर्ण हुआ है उद्योग के अनुसार सहमति मुद्धों पर तथा सबसे अच्छे तरीके से इन्हें आगे बढाया गया है। इसको विनियामक द्वारा सुविधाएँ प्रदान करते हुए प्रारंभिक जोर देने की आवश्यकता है।

किन क्षेत्रों में आप स्वयं विनियमन को प्रभावशाली समझते हैं ? क्या आप इसके लिए कोई कारण दे सकते है ?

जीवन बीमा काउंसिल का अधिकांश समय जीवन बीमा की प्रारंभिक बाधाओं को पहचानने तथा उनके समाधान की कार्ययोजना बनाने में होता है। समय आ गया है जब अधिक सार्थक मुद्धों को सम्बोधित किया जाए।

1) जीवन बीमा उद्योग का उत्तरदायित्व विकास

2) उपभोक्ता के हितो की रक्षा

3) स्वयं अनुशासन का प्रवर्तन करना

ऐसे क्षेत्र जिनमें ध्यान देने योग्य परिवर्तन आया है वह हैं :

- काऊंसिल ने स्वतन्त्र कार्यालय स्थापित किया है जिसके महासचिव कि नियुक्ति की गई है।
- विक्रय सोदाहरण में न्यूनतम अनुशासन के लिए क़रार हुआ है।
- मासिक सांख्यकि रिपोर्ट देना के लिए क़रार हुआ है जिसकी क्रियाविधि को अभी अंतिम रूप दिया जाना है।

आप भविष्य में कौन से क्षेत्रों का प्रबन्ध स्वयं विनियमित रूप से देखना चाहेगें ?

जितना अधिक उद्योग उत्तरदायी ढंग से स्वयं विनियमित होगा, उतना ही जीवन बीमा व्यवसाय के सम्पूर्ण स्वास्थय के लिए यह अच्छा होगा। विनियामक की और से उपर से निचे की ओर आज्ञा देना कम से कम होना चाहिये।

स्वयं विनियमन के सबसे महत्वपूर्ण क्षेत्र हैं:

1) उत्पाद अनुशासन क्या अन्दर आना चाहिये तथा क्या बाहर जाना चाहिये तथा कंपनी के लिए उत्पाद विभेद सक्षम होने चाहिये।

2) उत्तरदायी तथा अर्थपूर्ण विक्रय, गैर-कानूनी ऐजेंटों पर अनुशासनिक कार्यवाही

3) आँकड़ों का व्यापक प्रकटिकरण जिससे उद्योग में संवृद्धि का सही निर्धारण किया जा सके।

4) गैर प्रतियोगी पर करार, गैर डर की कार्यसूची तथा उसे समापन की तरफ ले जाना उदाहरण के लिए मृत्युदर तथा स्वास्थय की जाँच-पड़ताल बहुउद्देशीय विधि का ब्यूरो तथा सरलीकरण

5) वितरण के अतिरिक्त माध्यमों के ढाँचों, चाहे वह निगमित ऐजेंट हो, बैंकशोरंस हो अथवा विभिन्न स्तर का विप्पण इत्यादि हो (ऐसा मैं विश्वास करता हूँ कि काउंसिल ने निगमित ऐजेसी मार्गदर्शन प्रस्तावित किये हैं

पश्चिमी देश वित्तीय क्षेत्र में स्वयं विनियमन से दूर हो रहे हैं। क्या हम अवधारणा काल गणना में गलती कर रहे हैं ?

ऐसा सत्य नहीं है। विनियामक ने उद्योग में प्रचालन जटिलता के कारण विभिन्न मुद्धों में अपना योगदान बढाया है। विनियामक कि यह सक्रियता मिडिया के प्रकाश में भी आयी है लेकिन यह सक्रियता उद्योग की स्वयं विनियमन की कीमत पर नहीं हो सकती। स्वयं विनियमन समय उपभोज्य है क्योकि सभी सहभागियों को उच्च उद्योग लक्ष्यों के लिए सहमत होना होगा जो उनके छोटे समय के लक्ष्यों से संघर्ष करेगें और घीमे प्रतीत होगें।

जबकि वास्तव में वह प्रकृति समय ले रहे होगें। ज्यदातर बाजारों में स्वयं विनियमन का उदगम उद्योग को परिपक्वता तथा संवृद्धि देने के लिए महत्वपूर्ण दिशा प्रदान करता है।

Report Card: GENERAL

May growth up at 17 %

G. V. Rao

May 2005 has turned out to be a better month than April, considering that the growth rate of 12.2 per cent in April has become 17.6 per cent in May. The market premium accretion in May was Rs. 242 crore, about Rs. 11 crore lower than in April that must have had a lot of corporate renewals at the beginning of the new financial year.

To the accretion of Rs. 242 crore, the established players have contributed Rs. 77 crore (seven per cent growth), the new players Rs. 164 crore (66 per cent) and ECGC just Rs. one crore increase. National that led growth rates through out the last two years has shown yet another fall in its May premium by Rs. 25 crore, bringing it suddenly to the 4th rank among the non-life insurers. Oriental and United India have emerged ahead of it. Oriental is in a growth mode increasing its accretion by Rs. 41 crore (17.3 per cent increase), slightly below that of New India's Rs. 44 crore (15.4 per cent) in the month. United India is up by Rs. 17 crore (6.5 per cent).

The month of May, however, really belongs to ICICI that has shown a record accretion of Rs. 65 crore (123 per cent growth). A performance that is equally noteworthy, in terms of percentage growth, is that of IFFCO, whose accretion is Rs. 40 crore (138 per cent). Bajaj that had the highest renewal premium of Rs. 80 crore in May 2004 among the new players could show only Rs. 19 crore accretion. Tata has turned in a growth of Rs. 25 crore ranking third in accretion rate among the new players. HDFC is one of the two new players that has put brakes on its growth and has lost Rs. two crore renewals; the other is Reliance that has lost Rs. four crore renewals.

It is clear that ICICI is in the forefront among the new players and is marching ahead by increasing its lead

GROSS DIRECT PREMIUM (within India) MAY, 2005

(Rs.in lakhs)

INSURER	PREMIUM 2004-05 FOR MAY '05	PREMIUM 2004-05 UPTO MAY '05	PREMIUM 2003-04 FOR MAY '04	PREMIUM 2003-04 UPTO MAY '04	MARKET SHARE UPTO MAY, 2005	GROWTH % YEAR ON YEAR
Royal Sundaram	3,205.63	8,280.00	1,944.00	5,646.00	2.08	46.65
Tata AIG	5,089.09	12,812.31	2,600.18	10,033.07	3.22	27.70
Reliance General	1,014.26	4,062.52	1,572.23	3,769.49	1.02	7.77
IFFCO-Tokio	6,923.64	16,574.09	2,947.60	8,089.01	4.17	104.90
ICICI-Lombard	11,798.50	32,016.14	5,271.38	16,723.26	8.06	91.45
Bajaj Allianz	9,862.61	22,854.73	7,964.89	16,050.95	5.75	42.39
HDFC Chubb	1,147.03	2,543.32	1,341.54	2,594.71	0.64	-1.98
Cholamandalam	2,174.58	5,745.68	1,280.62	3,574.87	1.45	60.72
New India	32,920.00	84,437.00	28,532.00	76,812.00	21.25	9.93
National	28,016.00	65,254.00	30,484.97	69,535.92	16.42	-6.16
United India	28,051.00	66,083.00	26,317.00	64,088.00	16.63	3.11
Oriental	27,690.00	68,049.00	23,591.00	60,701.00	17.12	12.11
ECGC*	3,903.56	8,717.15	3,758.81	6,917.36	2.19	26.02
TOTAL	**161,795.90**	**397,428.94**	**137,606.21**	**344,535.64**	**100.00**	**15.35**

*The insurer has revised premium figure for April 2005 to Rs.48.13 crore.

position by a bigger margin. The rate of quantum accretion in May of the new players is more than twice that of the established players showing that the latter is losing market share even more rapidly.

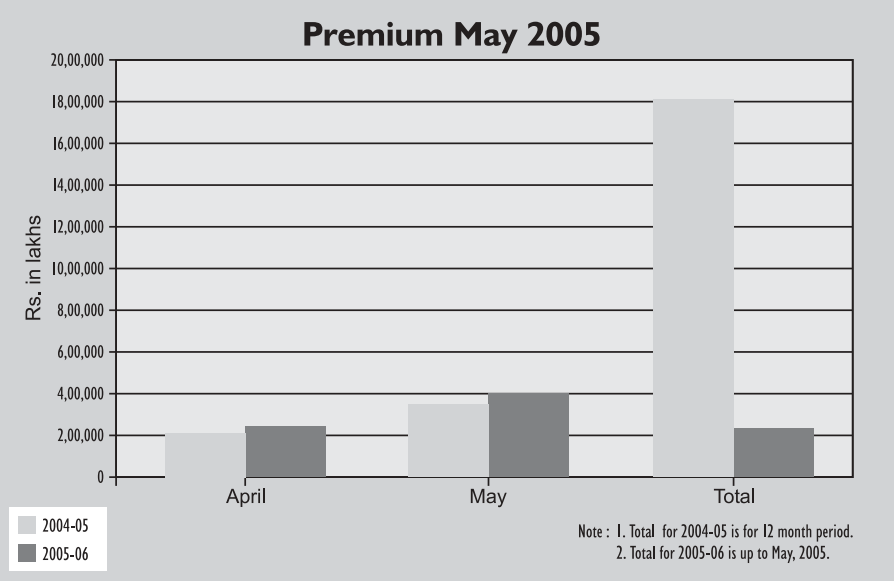
Performance up to May 2005

The premium up to May 2005 has touched the Rs. 3,975 crore mark with a market premium accretion of Rs. 529 crore (15.35 per cent), an impressive increase indeed. The quantum increase of the new players is Rs. 384 crore (57.6 per cent), more than thrice that of the established players whose accretion is Rs. 127 crore (4.7 per cent). The comparison demonstrates the raw competitive power of the new players that has put a squeeze on the growth potential of the established players, despite the penchant of the latter for Motor and Health premiums; and in a short span of time too.

There are two new players whose quantum accretions continue to be more than those of the established players. ICICI has an accretion of Rs. 153 crore followed by IFFCO with Rs. 85 crore. New India, the market leader in quantum premium has only Rs. 76 accretion with Oriental recording Rs. 73 crore. National has lost Rs. 41 crore showing a change in its market strategy.

The market share of the new players has climbed to 27 per cent at the end of May 2005 compared to 20 per cent last year.

With a premium growth rate of only 4.7 per cent and with wage revisions for staff due retrospectively, how will the established players contain their management costs within acceptable limits? With a larger market share of Motor and Health businesses that are heavily loss-prone and with the low premium growth rates, pushing the management costs up, the position they are placed in is challenging. But the good news for them is the booming stock market that may yet give them bumper profits on disposed assets.



The market share of the new players has climbed to 27 per cent at the end of May 2005 compared to 20 per cent last year.

The structural and strategic deficiencies, unless redressed to make the core business of insurance operations less unprofitable, will have a more damaging effect on the insurers in the long run. Detariffing may be one of the quick answers to meet competition; but the wish is unlikely to be granted soon. If they do not know how to optimise on their latent inherent strengths, they must at least know how to play on the weaknesses of the opponents. A fresh corporate marketing strategy and an overhaul of human resources have to be devised, if the ones in use are not working.

The author is retired CMD, The Oriental Insurance Company.

FY 2004-05: GENERAL

Personal Lines Make up 78% of Accretion

G. V. Rao

The financial year 2004-05 has ended and the non-life insurers have begun to count their gains and losses. The public sector companies will take a little longer to complete the process. But, in the meantime, it will be interesting to examine the changing trends in the portfolio structures of the market and comment on their movements.

It is not enough if a count of only the monthly premium growth trends is kept up: but it is also necessary for all concerned to be aware of how the portfolio structures are moving in the market, and how the insuring public and the insurers together are shaping it; and in what insurance covers the levels of risk-awareness in the public is growing

This write-up will report, analyse and comment on the changing portfolio structures and the preferences indulged in by the insuring public and the individual insurers. It will also see how the insuring public in response to the stimuli given by them is influencing the market trends. The analysis may also provide an input to each of the players, just when they have started setting their sights on the next milestones of achievements in their annual targets, in shaping the market behaviour.

Market Growth - Players' choice

The market in 2004-05 grew by Rs. 1,972 crore (12.7 per cent growth) to record a premium level of Rs. 17,593 crore, excluding the contribution of ECGC. Of this, the four established players have contributed Rs. 686 crore (5.1 per cent) by completing Rs. 14,048 crore and the new players have added Rs. 1,286 crore (57 per cent) by recording a premium of Rs. 3,545 crore. ECGC has grown by Rs. 73 crore and has completed Rs. 518 crore.

The market drive and momentum for growth is obviously in the hands of the new players, as the above growth trends show. In 2004-05, National Insurance among all the players had a solo run in premium increase by a massive accretion of Rs. 408 crore (10.7 per cent). UIIC was the lone insurer among all the players to record a fall in premium by Rs. 115 crore (- 3.7 per cent). Two established players, belonging to one owner, tackling the market in two extreme fashions.

Among the new players, ICICI and Bajaj are the two major players that have driven the insurance market up by spectacular premium additions of Rs. 380 crore and Rs. 376 crore respectively, accounting for 58 per cent growth among the eight new players. Their appetite for acquiring profitable segments of business is keen.

The dominant portfolio growth in 2004-05 has, of course, been in Motor that grew by Rs. 1,042 crore, (16.1 per cent)

Portfolio Movements

The dominant portfolio growth in 2004-05 has, of course, been in Motor that grew by Rs. 1,042 crore, (16.1 per cent), Health Rs. 378 crore (28 per cent) and Personal Accident Rs. 129 crore (36 per cent).

Fire business grew only by Rs. 172 crore (5.4 per cent), Engineering Rs. 127 crore (18 per cent), and Marine by Rs. 118 crore (10.2 per cent). Aviation and Liability portfolios have shown a cumulative fall of Rs. 162 crore, one due to fall in international rates and the other due non-renewal of a few special contingency policies. The other miscellaneous insurances, apart from those of ECGC, grew by Rs. 170 crore (10.8 per cent). What do these portfolio movements signify?

Portfolio Analysis

Though the Fire portfolio grew by a meagre Rs. 172 crore (5.4 per cent), the established players have lost an additional Rs. 36 crore over last year, yielding more space to the new players in the most profitable portfolio of all. The big losers are United India (Rs. 42 crore) and Oriental (Rs. 29 crore.) The big gainers are Bajaj, up by Rs. 103 crore, IFFCO by Rs. 34 crore and ICICI by Rs. 30 crore.

In the Marine portfolio, the impressive gains for the market are in the Hull segment recording an increase of Rs. 70 crore (15 per cent growth), whereas Cargo is up by Rs. 42 crore (six per cent). Here the losers are United India (Rs 56 crore) and New India (Rs. six crore.) National has performed most impressively with a massive increase of Rs. 68 crore, mostly from the Hull sector. From the new players ICICI has recorded an increase of Rs. 39 crore from both the Cargo and Hull sectors.

In the Motor TP section, the picture is a little confusing. It shows that the market grew by only Rs. 38 crore (1.6 per cent); with the new players recording an increase of Rs. 74 crore (94 per cent) and the established players showing a fall of Rs. 36 crore (-1.8 per cent), with United India dropping Rs. 130 crore and Oriental picking up Rs. 60 crore. National, surprisingly, has grown by only Rs. 10 crore. Could this really be happening? Is there a sudden loss of demand for this cover? One may have to await the audited figures on this.

In the Motor OD sector, the established players grew by Rs. 570 crore (15.2 per cent) and the new players by Rs. 437 crore (68 per cent). National led with a massive increase of Rs. 307 crore (27.8 per cent) and United India increased its share by Rs. 35 crore. Among the new players, Bajaj leads with a growth of Rs. 101 crore, with ICICI

up by Rs. 96 crore, IFFCO up by Rs. 86 crore, Tata by Rs. 67 crore and HDFC by Rs. 45 crore. The new players seem to have ventured out into the hitherto fearsome Motor territory, though it seems that it is restricted only to private cars and two-wheelers.

This move will put further pressure on the established players to shift into the even more unprofitable sectors of buses and commercial vehicles, more purposefully, should their premium hunger continue unabated.

In the Engineering sector that grew by Rs. 127 crore (18 per cent), the gains of the established players are a meagre Rs. 24 crore (4.5 per cent). ICICI with Rs. 46 crore increase and Bajaj with Rs. 31 crore have almost doubled their premiums.

The above analysis shows that the established players really are on the run, in almost all the portfolio sectors, yielding space more rapidly than what one thought was possible. With no change in any aspect of their management, either in style or substance, they seem to be fighting for their market shares, with the same old outdated weapons and battle formations. They seem to be still searching for a management mantra that will slow down the onslaught from the new players, if not stop it altogether. Will the present strategy work?

Customer-driven?

It will be seen from the trends above that nearly 78 per cent of the market growth of Rs. 1,972 crore, barring ECGC, amounting to Rs. 1,548 crore has come in from Motor, Health and Personal Accident segments, all essentially customer-driven insurance covers and quite high-loss prone; and not particularly popular with insurers. It is obvious, therefore, that the market is growing in the manner shaped by the insuring public for their benefit, in high-risk covers and not as developed or desired by any particular initiatives of insurers.

CHANGING MARKET SHARES

Portfolio	2003-04 %	2004-05 %	Market premium 2003-04		Market premium 2004-05	
			Rs. crores	%	Rs. crores	%
Fire	77.3	72.3	3,180	20.4	3,352	19.0
Marine	83.9	78.2	1,160	7.5	1,278	7.3
Engineering	75.8	67.2	708	4.5	835	4.7
Motor	88.8	83.6	6,457	41.5	7,498	42.6
Health	89.5	82.4	1,354	8.7	1,732	9.8
PA	78.6	68.3	360	2.3	489	2.8
Liability	65.3	51	362	2.3	349	2.0
Others	73.4	68.3	2,010	12.9	2,060	11.7
Total	85.6	80	15,621		17,593	

Market-driven?

The growth in Fire, Engineering and Marine segments — an index of economic growth — where insurers provide insurance services, but do not necessarily make customers buy insurance, is about Rs. 419 crore; and this is about 20 per cent of the overall growth. The motivation to go in for these insurances is more the compulsion of the financial institutions.

Nearly 78 per cent of the market growth of Rs. 1,972 crore, barring ECGC, amounting to Rs. 1,548 crore has come from Motor, Health and Personal Accident segments.

With 92 per cent of the growth, as seen above, coming in either in customer-driven or market-driven segments, one can question the insurers as to what they have particularly done to raise the levels of risk awareness among the uninsured to push up the market penetration?

Market innovators or mere service providers?

Making insurance services available is not the same as developing the insurance market. Neither is competition for the already created market a particularly desirable initiative from the uninsured public's point of view. Like in the case of life insurance, insurers have to push customers to buy covers for their "unarticulated needs." Do non-life insurers know what these are? If yes, have they designed covers that are affordable? Have they discovered distribution vehicles that are cost-effective? Judged from this perspective, non-life insurers have a long way to go to catch up with the highly developed prospecting and marketing skills of the life insurers.

A brief analysis of portfolio trends

The portfolio shifts also point out that insurers are not currently selling enough insurance covers in risks that are profitable to them; but are selling more

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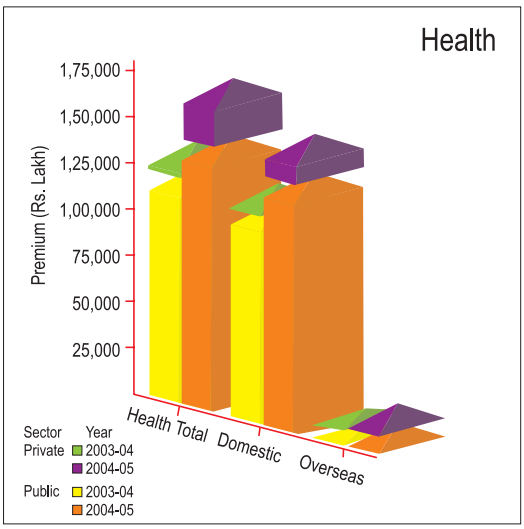
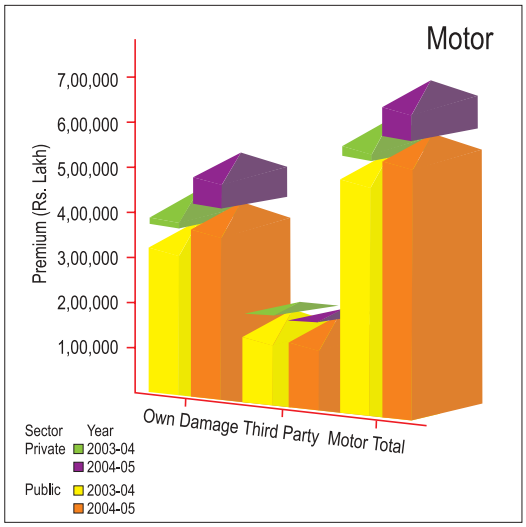
MARKET SHARES

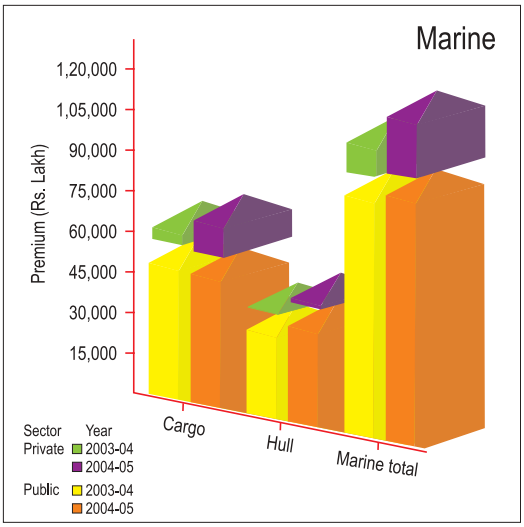


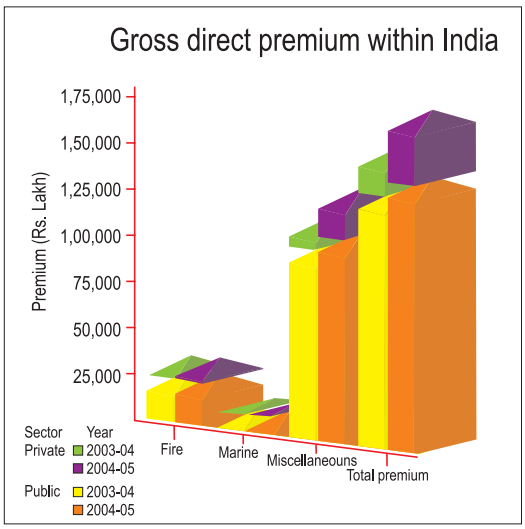


SEGMENT-WISE GROSS DIRECT PREMIUM

Insurer	Year	Fire	Marine	Marine Cargo	Marine Hull	Engg.	Motor Total	Motor OD
Royal Sundaram	2004-05	62.90	17.03	16.56	0.47	27.31	161.65	137.74
	2003-04	51.79	13.77	13.77		18.93	130.45	114.95
Tata AIG	2004-05	88.05	41.23	41.23		14.42	204.99	189.63
	2003-04	81.75	30.90	30.90		10.36	133.58	122.89
Reliance	2004-05	44.55	46.87	11.65	35.22	11.09	17.09	16.19
	2003-04	46.36	47.54	11.86	35.68	13.19	14.34	12.88
IFFCO-Tokio	2004-05	177.42	31.00	27.99	3.00	52.12	161.17	139.62
	2003-04	142.89	24.49	22.11	2.38	37.18	61.98	53.67
ICICI Lombard	2004-05	284.42	82.53	39.17	43.36	96.52	128.89	112.26
	2003-04	253.87	44.16	22.22	21.94	51.03	17.80	16.34
Bajaj Allianz	2004-05	221.84	42.51	33.76	8.75	61.65	347.82	292.22
	2003-04	119.27	20.79	18.57	2.22	31.41	222.69	190.71
HDFC Chubb	2004-05	1.63	0.40	0.40		0.98	153.31	144.39
	2003-04	0.36	0.02	0.02		0.24	105.49	99.22
Cholamandalam	2004-05	48.50	15.90	14.21	1.70	10.02	55.18	45.54
	2003-04	25.77	5.10	4.88	0.23	8.47	35.62	30.14
New India	2004-05	794.90	253.22	147.27	105.95	136.73	1,817.44	1,203.71
	2003-04	775.20	259.22	158.21	101.01	142.00	1,679.20	1,088.71
National	2004-05	542.79	261.50	159.15	102.35	114.58	1,981.27	1,414.14
	2003-04	526.70	193.80	149.39	44.41	109.46	1,664.61	1,107.17
United India	2004-05	590.08	244.88	128.48	116.39	157.77	1,124.58	802.35
	2003-04	632.41	300.74	133.89	166.85	142.88	1,219.65	767.31
Oriental	2004-05	494.61	240.83	127.91	112.92	151.45	1,344.48	886.33
	2003-04	524.00	218.93	132.40	86.53	143.05	1,171.11	772.70
ECGC **	2004-05							
	2003-04							
Total	2004-05	**3,351.70**	**1,277.89**	**747.77**	**530.11**	**834.63**	**7,497.88**	**5,384.12**
	2003-04	3,180.38	1,159.46	698.21	461.25	708.20	6,456.51	4,376.70

* Previous year data may not be comparable with the audited published figures.
** Pertains to Credit Insurance.





WITHIN INDIA : 2004-05 (PROVISIONAL)

Rs. in Crores

	Motor TP	Health	Aviation	Liability	Personal Accident	All Others	Total	Market Share
	23.91	30.02		4.59	23.94	4.06	331.50	1.83
	15.50	15.90		3.20	20.75	3.23	258.02	1.61
	15.36	26.64	0.03	47.48	39.09	6.93	468.87	2.59
	10.69	19.69	0.91	44.10	27.26	4.77	353.32	2.20
	0.91	7.98	6.32	7.73	4.49	15.56	161.68	0.89
	1.46	7.79	6.53	11.86	4.19	9.25	161.06	1.00
	21.54	28.37	0.00	7.41	15.03	34.89	507.39	2.80
	8.31	0.00	0.00	5.34	3.93	19.83	295.64	1.84
	16.63	118.78	7.90	71.96	51.35	42.82	885.17	4.89
	1.46	52.46	7.59	48.43	11.57	19.81	506.72	3.15
	55.61	70.39	0.91	19.53	10.62	77.49	852.75	4.71
	31.98	37.05	1.19	7.03	7.56	29.32	476.31	2.96
	8.92	1.97		1.68	7.45	10.34	177.78	0.98
	6.27			0.14	0.90	4.52	111.67	0.70
	9.64	20.12	1.14	10.89	3.14	5.20	170.11	0.94
	5.47	9.15	1.89	7.42	0.96	2.31	96.68	0.60
	613.73	504.28	147.20	55.41	84.04	429.79	4,223.01	23.32
	590.49	396.05	259.65	43.96	73.56	416.84	4,045.68	25.18
	567.12	364.29	38.96	37.22	92.56	391.82	3,824.98	21.12
	557.44	288.47	47.52	126.80	48.01	411.64	3,417.00	21.27
	322.23	294.19	2.36	41.94	91.29	404.23	2,951.32	16.30
	452.34	279.53	25.57	22.66	88.63	354.82	3,066.89	19.09
	458.15	265.14	116.32	42.70	66.16	317.51	3,039.17	16.78
	398.41	248.15	119.32	41.06	72.86	293.63	2,832.11	17.63
						517.95	517.95	2.86
						445.13	445.13	2.77
	2,113.76	**1,732.17**	**321.13**	**348.53**	**489.16**	**2,258.58**	**18,111.67**	**100.00**
	2,079.81	1,354.25	470.17	362.00	360.17	2,015.08	16,066.23	100.00

Contd. from page 41

covers that are inherently more unprofitable to them like Motor, Health and PA. In risk acceptances, while it can be argued that rates in Motor business are tariff-driven and covers are compulsory to an extent, it is not the same in the Health and Personal Accident businesses that are insurer-dictated in respect of rates, and yet they are making more percentage losses in them than in Motor. Why is it so? Is there a deficiency in the management of portfolios? Or is it due to too much appetite to grow rapidly?

The message the insurers are sending the public by these business practices is rather confusing. What do insurers really want? Cash-flow premiums? Are they capable of making risk acceptances that are price-sensitive that provide them with a slight margin? If they are not cost-conscious, as their bloated administrative costs indicate, and are not margin –conscious, as their risk-acceptances seem to suggest, how good are their underwriting and management skills? How long can this approach persist without damaging their market credibility?

Market Shares:

The market share of the new players, excluding ECGC, has moved up from 14.4 per cent to 20 per cent, while the established players have moved down from 85.6 per cent to 80 per cent.

The market share of established players in each portfolio and the changing composition in each is shown in the table above.

It will be observed from the table that except in the Motor and Health segments, the established players have lower market shares than the average market share of 80 per cent in every other portfolio. Is there a message? In fact, in the liability segment ICICI is ahead of all the players in its volume.

In the Engineering and Fire portfolios, the private players have scored impressively, despite their low paid-up capital bases and lack of infrastructure; in addition to the fact that the public sector enterprises seemed to prefer the established players due to past relationships, financial security they offered and an ingrained sense of safety in dealing with another public sector enterprise. It is an extraordinary feat.

The new rising stars

The new rising star in Fire growth in 2004-05 is Bajaj with an impressive accretion of Rs. 103 crore. In Marine, Engineering and Health, it is ICICI with an accretion of Rs. 39 crore, Rs. 46 crore and Rs. 67 crore respectively leading the others. In the Motor segment too, Bajaj and ICICI have each shown increases in excess of Rs. 100 crore. IFFCO is a close third to them.

> Insurers are not currently selling enough insurance covers in risks that are profitable to them; but are selling more covers that are inherently more unprofitable to them.

What next on the agenda?

It is clear that the new players are targeting, laser-like, the profitable customers in each one of the portfolio segments including Motor. The established players, with their high costs, outmoded reporting systems and inevitable loss of controls on how business is actually done at the grass roots, are left with managing mainly their investment portfolios rather than the insurance business, on which the real controls are exercised by the divisions and branches. How to offset the operational losses by enlarging the investment earnings is the main preoccupation of the established players. The context of the terms of reference of market operations has changed.

The boom in the stock market may mislead and blind them to the situation on the insurance operations front and provide them with a false sense of a successful management of their overall business. The organisational structures, the mindset of the staff and the lack of accountability from the top downwards for things that have gone wrong, by blaming all external factors except their management capabilities have not helped them so far. Fresh thinking and a dedicated commitment to organisational values in insurance operations, as defined by customers are necessary.

There is a huge opportunity for them to pioneer development of semi-urban and rural insurances in a big way with their vast infrastructure. They have the expertise and experience of having built up rural insurance business in the past.

But the private players buoyed up by their success will not allow the established players any room to manoeuvre. The going is tough. But are the established players tough enough to get going? The future cannot be a continuation of the past. Or can't it?

The author is retired CMD, The Oriental Insurance Company.

LIC TO ROLL OUT MICROINSURANCE POLICIES FOR RURAL MARKETS

LIC is planning to introduce certain highly affordable individual policies, with the sum insured being as low as Rs. 10,000-15,000, for the rural poor, say media reports. The microinsurance policies will be distributed through non-governmental organisations (NGOs) and self-help groups (SHGs). The size of the policy is very small compared to the regular policies, where the minimum value is Rs. 50,000 per policy.

Though the premium is small, security will not be compromised upon, Mr. T. S. Vijayan, Managing Director, LIC, has been quoted as saying.

LIC is awaiting final guidelines for microinsurance from IRDA, and is likely to receive within two months. Going by the success of microcredit schemes offered by banks, the new LIC products are projected to perform well. The corporation has already established an internal task force to work out the details of the schemes.

As per IRDA's draft guidelines on microinsurance, the minimum amount of cover should be Rs. 10,000, with a minimum term cover of five years and a maximum of seven years. While the minimum age at entry should be 18 years, the maximum age should be 60 years. The products can be distributed by individual insurance agents, corporate insurance agents, insurance brokers or micro-insurance agents, where the premium should not exceed 20 per cent of the premium in case of life insurance contracts and 7.5 per cent in case of general insurance contracts. The minimum number of members comprising an SHG should be at least 10 for insurance of individuals and at least 50 for group insurance.

Patni Computer introduces BPO solutions for insurance firms

Software services company Patni Computer Systems has launched business process outsourcing (BPO) solutions tailor-made for insurance companies, it has been reported.

The new solutions would allow insurance companies to offload common record-keeping tasks associated with the administration of all contribution plans. They also enable administrators to reduce overall program costs and improve the quality of service while focusing their internal resources on their core business activities.

As insurance companies increasingly deliver a wide range of financial-oriented services, apart from standard insurance products, it becomes pertinent to outsource non-core activities such as their IT needs.

A risk-covered trip to the Amarnath cave shrine

Shri Amarnath Shrine Board, which organises an annual pilgrimage to the 3,880 metre high cave shrine of Amarnath in Kashmir, plans to introduce insurance schemes for pilgrims. The move follows a high level meeting of the Board to discuss security aspects of the pilgrimage, which is typically held from mid-June to mid-August each year.

The Board is already in negotiations with insurance companies to provide a cover of Rs. 1 lakh to each pilgrim. The policy will cover natural as well as unnatural deaths. The insurance cover will be for a maximum of seven days starting from two days prior to the registered date for the pilgrimage.

Amarnath pilgrimages have traditionally been risk-filled. Every year nearly a dozen pilgrims die due to cardiac arrest, breathing problems and other natural causes besides slipping off the treacherous and hilly tracks from Pahalgam and Baltal to the holy cave shrine. Several dozens of pilgrims were killed in the mid-1990s, when a massive snow blizzard froze them to death.

Also, militants in the past have carried out several attacks to disrupt the annual pilgrimage.

A group policy that sparkles

When insurance companies' stance on a subject is rock-hard, even diamond cannot cut it, as the Surat Diamond Association realised. The association sought a group insurance cover for diamond workers in the city but the insurance companies could not offer a suitable product. Hence, the association decided to do it on its own, it is reported.

Nearly 18,000 diamond workers are now covered under a scheme operated by the Surat Diamond Association, according to newspaper reports. The association pays Rs. 1 lakh to the family of a member in the event of death and other defined amounts in case of serious disablement.

The 'Ratnakalakar Bima Yojana' scheme is in its second year of operation and the association targets to rope in at least one lakh members by the end of the current year. Nearly 17 claims have already been settled, where the payment was made within 15 days of the death of the member.

The annual premium, an affordable Rs. 225, is often paid in part or full by employers as a welfare measure. The profits under the scheme are to be ploughed back for other welfare measures of the association. Plans are afoot to set up primary health centres in each of the 10 diamond polishing clusters of Surat.

'FAKE' ACCIDENT CLAIMS HAVE INSURERS UP IN ARMS

Rising accident claims have put the four public sector general insurance companies in a tight spot, as they reportedly pay over Rs. 100 crore as accident claims per year in Tamil Nadu alone, say media reports.

Insurance company officials allege that in most hit-and-run cases, claims are fixed (at a later stage) by the inspecting officers. According to records, only 20 percent of vehicles on the road have valid insurance cover.

Following complaints of exaggerated and bogus claims, Mr. A. Subramanian, Inspector General of Police (West Zone), began reinvestigations and placed nearly 370 cases in the 'doubtful' list for exaggerated and bogus claims. Erode tops the list with 129 bogus claims, followed by Coimbatore District at 56, Namakkal 49, Salem city 40, Dharmapuri 15, Krishnagiri 20 and Nilgiris with one case.

Some vehicles, the officials claim, were falsely implicated in more than one accident case. They allege a nexus between advocates, police and some RTO officials.

Consumer body raps insurer, car financier

A car finance company, whose cheque for insurance cover bounced, causing hardship to the car owner after his car met with an accident, has been asked to pay up to the car owner, it has been reported. In turn, the insurance company too has been directed to compensate the car financier for not informing them about the expiry of insurance cover.

Mr. Sunil Malhotra, the consumer, bought a Santro with RR Financial Consultants. The insurance cover, as per the agreement, was to be provided by the financier. Although Mr. Malhotra paid the premium to the financier, the cheque deposited by the latter with United India Insurance bounced. United India had mentioned the insurance renewal to the financier. On October 16, 1999, a few days before the expiry of the insurance policy, the car met with an accident.

After an FIR was filed, UII was approached for the insurance cover, at which point it informed that the cover could not be extended because the cheque had bounced.

The Consumer Commission pointed out that financiers were at fault since they had been paid the insurance premium by Mr. Malhotra. Holding them liable for the entire episode, the Commission ordered the financier to pay the premium to Mr. Malhotra. It also held the insurance firm indictable, pointing out that neither the financier nor car owner were informed about the bounced cheque.

INSURANCE PRODUCTS FOR CASH CROPS

Agriculture Insurance Company of India Ltd. (AIC) plans to introduce exclusive products covering cash crops such as tea, rubber and sugarcane in July, it has been reported. After designing the products for tea and rubber, AIC will approach IRDA for final approval.

An exclusive insurance scheme for sugarcane will also be introduced after clearance from the Agriculture Ministry. The company is also doing the groundwork to introduce a dedicated insurance scheme for cotton.

AIC was established in December 2002 with the mandate to develop exclusive crop insurance schemes including weather-based products in the country. The company, which is promoted by General Insurance Corporation of India (35 percent), NABARD (30 percent) and four public sector general insurance companies (8.75 percent each), has an authorised share capital of Rs. 1,500 crore and initial paid-up capital of Rs. 200 crore.

Industry observers have noted that for an agri-based economy, India has too few insurance policies customised for that sector. The government has been mooting the development of special insurance products for agriculture.

Insurer balks at number of police deaths

The New India Insurance Company Ltd., the insurance company for the Mumbai and Maharashtra police, has unexpectedly ended its contract with the Mumbai police. The reason? Too many police deaths in a single year.

Quoting company officials, media reports say that the significant spurt in the number of deaths has forced the insurer to pay exorbitant amount of claims, eventually resulting into losses for itself. The contract was signed in December 2002 and was for a period of three years, ending in December 2005. The contract was ended prematurely with immediate effect, stating that it "wasn't commercially viable".

The company had received a yearly premium of Rs. 80 lakh from the police department and, in comparison, the number of policemen who died was greater. "We ended the contract because nearly 100 policemen in Maharashtra died in the last one year and with a premium of Rs. 80 lakh from the police department, the company had to pay claims, worth more than Rs. 1 crore. After this we even started receiving memos from the head office, blaming us for entering into an agreement that was actually reducing the company's income," a company official has said.

Oriental Insurance Company Ltd. has now taken over as insurance providers for the Mumbai and Maharashtra police. A senior official from Oriental was quoted as saying that unforeseen accidents and events would keep happening.

The sudden increase in police deaths is attributed mainly to accidents and health related issues. Police records reveal that out of the total 290 policemen who have died in the past five years, close to 150 died because of cardiac failure, stress, hypertension, tuberculosis and other health related problems. The others died in accidents.

European insurance market stable: S&P report

Standard & Poor's Ratings Services has published its quarterly report on the leading European insurers. The *Industry Report Card: European Insurance* study concludes that the current picture for the market is stable, with "good results expected to continue in 2005". The report also identifies trends that will have a significant impact on the profitability of the insurers in the future.

According to media reports, S&P expects quarterly results to continue to show positive earnings momentum. "Non-life results remain excellent, and we expect 2005 to be a record year for underwriting profits," Mr. Hans Wright, S&P credit analyst, has reportedly said. "Investment conditions also continue to be favourable, with limited exposure to the Ford and GM debt downgrades and higher interest rates generally having a positive impact for insurers...The majority (66 percent) of all insurer financial strength ratings in Europe remain stable."

S&P concluded, however that "premium rates in 2004 and 2005 for the non-life market are softer in real terms, so underwriting losses are expected to deteriorate based on business written today". Wright has indicated that ratings will be "driven by the ability to maintain underwriting discipline in the face of weaker pricing. Continued resilience over the next 12 months could be positive for ratings. For now, those companies that are able to demonstrate superior discipline may command a positive outlook, but upgrades would not be expected at this stage in the underwriting cycle."

In the life sector, S&P observed that "pricing on new business is more rigorous, with more active asset-liability management and cost reduction programmes also set to contribute to profit enhancements in the future. The dominant rating factor will be whether life companies can achieve growth at attractive margins without additional risk."

Comparing life and non-life revealed that the latter has a shorter life cycle, and consequently, "new business performance feeds through to the bottom line more quickly for non-life business than for life business. The question remains whether life insurance performance will improve sufficiently to compensate for the expected weaker non-life earnings. This will be a particular issue for insurance companies operating in both the life and non-life markets."

'US terrorism insurance no match for risk present'

The terrorism insurance system in the US is failing to provide businesses with adequate financial protection, according to a study conducted by RAND Corporation. The study says the nation is vulnerable to economic disruption if there is a major terrorist attack.

The report, submitted by the RAND Center for Terrorist Risk Management Policy (CTRMP), said the terrorism insurance system is not robust enough to respond to a rapidly evolving terrorist threat against US businesses.

"America's economy does not have adequate financial protection from terrorist attacks," Mr. Peter Chalk, a RAND terrorism expert and lead author of the report, has been quoted as saying. "Protecting businesses against the economic impact of a terrorist attack should be part of a robust homeland security effort." Other authors of the study are Mr. Bruce Hoffman, Mr. Robert Reville and Ms. Anna-Britt Kasupski of RAND.

The study points out that terrorism insurance does not cover losses caused by attacks from domestic terrorist groups. In addition, it said most insurance polices now exclude coverage for attacks involving chemical, biological, radiological and nuclear (CBRN) weapons.

MAKE SKYSCRAPERS SAFER, SAYS US STUDY

The US Commerce Department's National Institute of Standards and Technology (NIST), which investigated the fires and collapses of the World Trade Center's twin towers following the September 11, 2001 terrorist attack, has reportedly recommended various skyscrapers safety measures. These include changes in building standards, fire codes and emergency response methods.

The NIST goes not have the authority to require changes in building codes and standards. However, since its 30 recommendations are based on the findings of the most detailed examination of a building failure ever conducted, they are likely to be taken seriously. "We believe these recommendations are both realistic and achievable within a reasonable period of time, and should greatly improve the way people design, construct, maintain and use buildings, especially high-rises," Mr. Shyam Sunder, WTC lead investigator, was quoted as saying.

The recommendations, contained in about 10,000 pages, have been released for a six-week public comment period. The recommendations on improving structural integrity call for more reliable means of predicting failure in structures subjected to multiple hazards and nationally accepted standards for wind tunnel testing of prototype structures and estimating wind loads for tall buildings.

Chinese insurers allowed to invest overseas

The China Insurance Regulatory Commission has announced that domestic insurers will henceforth be allowed to invest in stocks overseas. As per the new rules, Chinese insurers can invest their foreign currency in stocks listed on exchanges of "mature" markets overseas. To start with, the companies will only be allowed to invest in Chinese companies listed abroad, but this restriction could be relaxed later, depending on the capability of the insurers' management and the environment in international markets.

Industry observers have noted that while the decision is an important one, its short-term impact will be minimal. Chinese insurers hold an estimated $10 billion in foreign exchange funds, and their overseas investments are subject to quotas, so the amount to be freed up by the new rule is not large relative to total domestic liquidity. Savings alone is estimated at around 8 trillion yuan ($966 billion) in China.

Insurers will be required to cap investments in overseas shares at 10 percent of the total foreign exchange investment quota already allotted by the Regulator. Insurers must also limit their investments in a single company to 5 percent of its total stock.

Ping An Insurance Group Co. is so far the only insurance firm that has been given an overseas investment quota, of $1.75 billion.

SARBANES-OXLEY MAY BE REPLICATED FOR PRIVATE INSURANCE FIRMS

A variation of the controversial Sarbanes-Oxley auditing reforms may soon apply to private insurance companies in the US, say media reports.

The National Association of Insurance Commissioners has proposed adding elements of the Sarbanes-Oxley Act of 2002 to its audit rules. The NAIC, an organisation representing insurance regulators for all the 50 US states, has been working on the amendment in a joint work group with the American Institute of Certified Public Accountants. If approved, the new audit rule would apply to privately held insurance carriers and mutual insurance companies, according to Mr. Kirk Schmidt, who directs financial regulation for the Missouri Department of Insurance. It would not be mandatory, however, for states to accept it as a statute or a regulation.

The proposal faces stiff opposition from industry groups such as the Property Casualty Insurers Association of America and the National Association of Mutual Insurance Companies. These bodies argue that elements of Sarbanes-Oxley have no place in the privately held insurance world because the law was exclusively designed to protect public company shareholders. Policyholders own and control mutual insurance companies.

Passed by the US Congress in the wake of financial reporting scandals at Enron Corp. and WorldCom Inc., Sarbanes-Oxley is part of the greatest overhaul of financial reporting and corporate governance for public companies since the 1930s. It has led to a precipitous rise in legal and accounting fees for many public companies.

Insurance industry going for more but smaller mergers

The total number of mergers and acquisitions in the insurance industry increased in 2004, driven by the health/managed care and distribution sectors, says a recent study conducted by Conning Research and Consulting. However, the value of the mergers is lesser than previous years.

Although the merger transaction total rose over the prior year for the first time since 2001, the total transaction values were less than $ 15 billion, the second lowest in a decade.

"More M&A activity is likely to stimulate more and larger transactions, but projecting the when, where, and why requires a deep examination of the conditions in the individual sectors," Mr. Clint Harris, a Conning analyst, was quoted as saying. "Certainly, we found consolidation plays in the health/managed care sector, but we also identified them in the property/casualty and life sectors. They may seem less dramatic than the mega-mergers in 2003 and 2005, but these smaller deals are definitely shaping the industry environment."

The industry is continuing a slow but noteworthy progression toward consolidation, the report noted. "While we have seen significant transactions in the various sectors over time, the industry remains highly fragmented and still very ripe for consolidation," said Mr. Stephan Christiansen, Conning's research director. "The 2004 transaction activity did more to reshape individual sub-segments in the market than to increase industry concentration, but we anticipate continued consolidation in the coming years, as companies strive for market position in the face of accelerating competition."

With-profits are not simple products to understand. Even though the concept of a smoothed investment product is relatively straightforward, how it operates in practice is still difficult for policyholders to comprehend.

Mr. David Strachan, Insurance Sector Leader, Financial Services Authority, the UK

(The regulator needs) to get the right balance between effective prudential supervision and excessive regulation.

Mr. John Laker, Chairman, Australian Prudential Regulation Authority (APRA)

My decision to resign now results from my inability to receive information regarding the company and its operations necessary to fulfill my fiduciary duties.

Mr. Maurice R. Greenberg in his resignation letter from the board of directors of American International Group Inc. which he led as Chairman for over four decades.

We could find a new partner for Sanmar or sell the entire business or even look at other investors.

Mr. Graham Meyer, Managing Director, AMP Sanmar Life Insurance

At every stage, the company has to keep us informed of a plan of action. We do not like a position where a partner is identified and later, we find that the partner does not fulfill guidelines.

Mr. C. S. Rao, Chairman, IRDA

One party's exit is not a signal, on status of insurance in the country. A growth of 35% and 15% is testimony of the markets' strength.

Mr. C. S. Rao, Chairman, IRDA

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Events

07 - 09 July, 2005
Venue: Pune
Multiple Distribution Channel Management (Life)
by NIA

07 - 09 July, 2005
Venue: Pune
Advanced Programme on Claims Management (Non-Life) by NIA

07 - 09 July, 2005
Venue: Pune
Latest Trend in IT Hardware and Software
by NIA

10 - 13 July, 2005
Venue: Hong Kong
Annual Seminar of the International Insurance Society

11 - 16 July, 2005
Finance Appreciation Programme
Programme on Networking (Non-Life) by NIA

21 - 23 July, 2005
Programme for Retiring Executives (Non Life) by NIA

18 - 27 July, 2005
Venue: Pune
Programme on Advanced IT Security (Life)
by NIA

25 July, 2005
Venue: Sydney
Australia & New Zealand Insurance Industry Awards
by Asia Insurance Review

26 - 27 July, 2005
Venue: Sydney
The New World of Liability Insurance

28 - 30 July, 2005
Venue: Pune
Management of Executive Stress (Non-Life)
by NIA

08 - 09 August, 2005
Health Insurance Scenario by NIA

11 - 13 August, 2005
Corporate Governance
Part of the Silver Jubilee Seminar series of National Insurance Academy

11 - 13 August, 2005
Programme on Cyber Laws by NIA