Volume I, No. 6

irda Journal

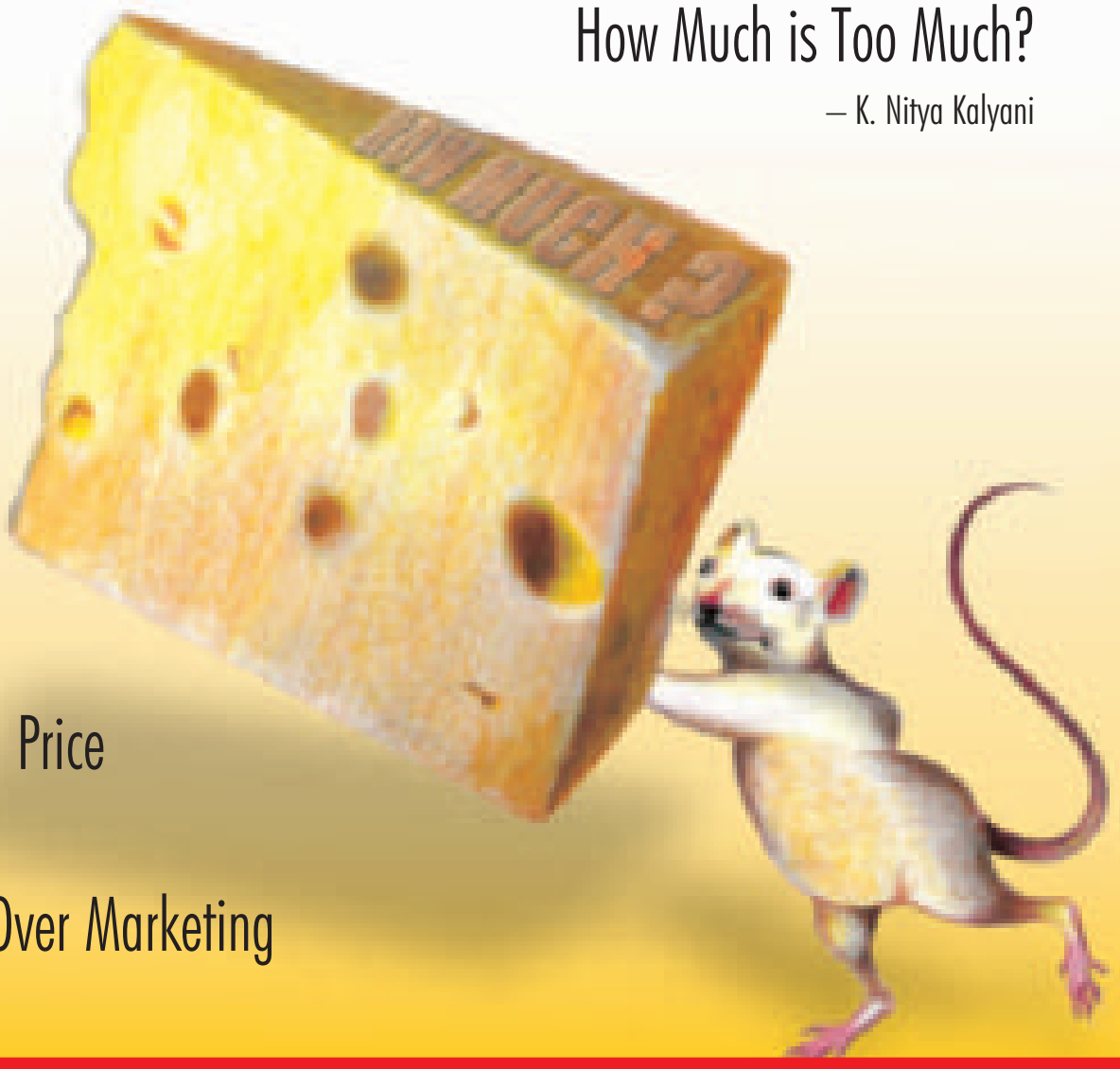
MAY 2003

Reporting for 'Value'

— Ashvin Parekh

How Much is Too Much?

— K. Nitya Kalyani



Rightsizing the Price

— Apparao Machiraju

Management Over Marketing

— G.V. Rao

बीमा विनियामक और विकास प्राधिकरण

Journal

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From the Publisher

One more issue of the Journal has been broughtout and is in your hands. This issue concerns the professionalised intermediaries and the costs of intermediation.

The Indian insurance market has so far seen only one type of intermediation, namely, the individual agent who used to trudge along on innumerable occasions to a prospect to convince him about the necessity of an insurance cover. We not only have changed this profile by making him a fully qualified professional, but have also added a variety of intermediation measures.

The introduction of these new measures, especially in the area of selling and distribution, calls for an appraisal of the pattern of remuneration so that it stands justified over a period of time. As things stand today, a life agent gets a substantial portion of the first year's premium as his commission and the level of commission for the Second year and onwards tapers off giving rise to issues on continuity of business, the propensity on the part of agents to canvass only new business ignoring the servicing of existing clients etc.

The Authority, therefore, felt that there could be an alternative to this by evening out the commission payment during the period of the life of a policy. It appointed a committee to examine this, which will furnish its report by the beginning of May.

The next issue I would like to share with the readers is that the Authority's point of view that a journal would be good communicator between the regulator and the public has been appreciated at the international level also. One of the good attributes for an efficient administration has been held to be the art of communication and the medium of communication between the regulator and the regulated in the shape of a journal or a magazine.

The provisional statistics regarding business done for the year ended March 2003, are appearing elsewhere in this journal. The Authority feels hopeful from figures that are available that the market is poised for growth and the development of the general insurance industry has been on the expected lines. The gross premium produced by the 13 companies registered for carrying on general insurance business is Rs. 14,279 crores which shows an increase of 25 per cent over the previous year. Certain segments of the general insurance industry have done well and they require to be complimented. The percentage of business of the private sector companies put together in the general insurance field has been nearing 10 per cent.

The figures of the life insurance business have come in and it is seen that the first year premium of the LIC of India has come down significantly. This has been due to the fact that the Corporation's sale of single premium policies, which accounted for a substantial business for the year 2001-02, has come down very much this year. Readers may also be aware that the Government itself is discouraging this business by making the amounts due under single premium policies, where the annual premium is more than 20 per cent of the sum assured, subject to tax. The character of the business of LIC of India this year has, therefore, been a little different from what it was last year. Despite this, the performance of the LIC has been very creditable. Even in this sector the private insurers have shown a mark and have taken 10 per cent of first year's business.

There have been some concerns over the lack of progress on the Health insurance front. An NGO, The Institute of Health Systems, based in Hyderabad, has shown some interest in the development of this business and has promised to comeup with proposals. I have requested them for a further elucidation of the plans. Some progress on this is expected in the coming weeks.

The popularity of the Journal seems to be growing as can be seen from the number of requests from persons wanting to be placed on the mailing list. We in the Authority anticipated a very slow and gradual progress and have been printing 1,250 copies so far. Due to the sustained support received from all of you, this number seems to be becoming smaller for the large following of readers the Journal seems to have created for itself. We, therefore, are increasing the print order from this issue to 1,500. We do hope that the discerning readership of this Journal will continue to support the Authority in the coming months.

N. RANGACHARY

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COVER STORY

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Looking Back, Looking Forward

We take up in this issue of IRDA Journal, the matter that has been bothering most insurers and all their intermediaries for a while now. How much to pay intermediaries? It is not only a question of affordability, but also one of strategy.

Brokers, agents, banks ... all sell insurance, various professions like Chartered Accountants and trades like travel agents and so on want to capture their clients for a new product. All this means that the question of how to create a productive and long-lasting marketing machine becomes more interesting and complex.

We have Mr. Apparao Machiraju speaking of various systems of compensation in the life insurance industry worldwide, their relative merits and likely outcomes. And Mr. G.V. Rao dealing with issues in the non-life industry.

We also introduce, through an article by Mr. Ashvin Parekh, the cover topic of our June issue – corporate governance. In the insurance industry, which has been a public sector monopoly for long and now has private companies that are closely held as well, disclosure will become a major crux of credibility.

In an indirect way this is reflected in the number of letters that the IRDA and the **IRDA Journal** get from prospective customers of the new insurance companies demanding to know if their money would be safe and whether their investment decision is a sane one.

While the IRDA Chairman sets these doubts at rest with his detailed reply to one such anxious letter in this issue, the larger question of financial soundness of the new companies will be established only through constant and conscious disclosure of financials and strategies by the companies voluntarily.

It would be valid to point out here that some new companies specially in the life sector have been fighting shy of talking about their bottomlines fearing a bad image with prospects (it's a different matter that many older companies are going through a bad time in terms of profitability as well). But this caution could well be counterproductive as it only creates more doubts in the minds of the customer. Instead a more productive gameplan for the industry would be to reveal working results in full and talk about how it got there and plans for the future. This will put things in perspective and the 'soundness' of the company and the safety of the policyholders' funds it holds in trust can clearly be shown protected by the capital levels and solvency norms and the regulator's monitoring of them.

It's in that spirit that we bring you companywise results of both the life and non-life industries because it's that time of the year when the world gets to know how we did all year. The year-end provisional business figures are in for you to read. This section has been one of the most popular and sought-after and we welcome suggestions on what you want to read and how you think we could present the figures better.

As you will see from the results, the public sector continues to hold sway but the private sector is making steady inroads, more than expected going by the experience in other markets.

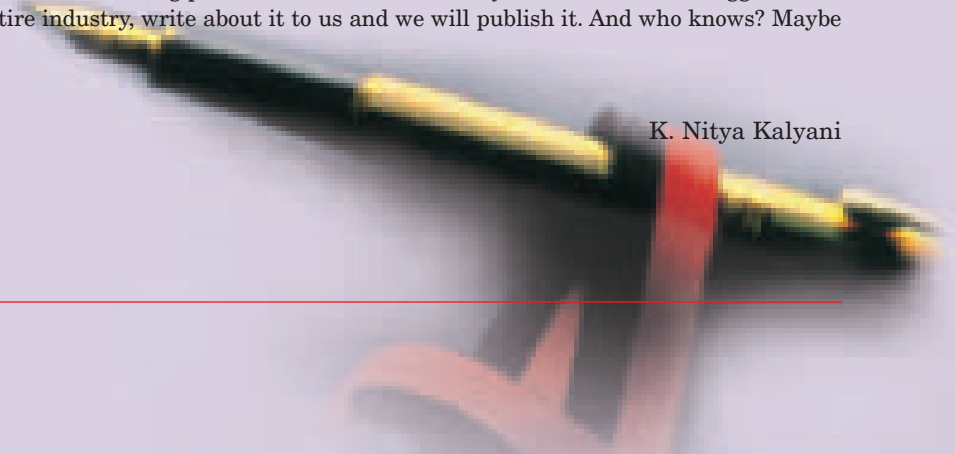
This shows that the market is being widened slowly but surely, something that was expected to happen with competition and new companies.

It will take a while to find out whether the companies are doing profitable business as well, but marketshare and cash flow for building an investment portfolio are valid targets to chase in the first few years for insurance companies.

Apart from interesting articles reacting to earlier issue focus topics, we have this time a new section called Public Domain where, from time to time, we will feature common cause initiatives that benefit the entire industry – as in the case of a common user facility being proposed – or even the entire society.

For this section we welcome articles that take the big picture into consideration. If you have an idea or suggestion or a dream project that will benefit the entire industry, write about it to us and we will publish it. And who knows? Maybe someone will want to implement it!

K. Nitya Kalyani



Reporting for 'Value'

In this issue we initiate a new topic – corporate governance in the Indian insurance industry – with an article by Mr. Ashvin Parekh. Corporate governance has been very fashionable talk in the recent years with the Enrons and Worldcomms of the world showing us how badly things could go wrong.

During this period, the pretty much ignored Cadbury report and the deliberations of our very own Naresh Chandra Committee have been in the news and analysis pages regularly, not to speak of being seminar topic favourites.

Corporate governance is likely to be a dreaded word too in corporate circles. Just recently, independent directors on some bank boards have declined to sign the covenants outlined by the Ganguli Committee Report on corporate governance on the grounds that they already sign agreements specifying their roles and duties when joining the bank boards. There is obvious resistance on the part of the watchdogs now that their roles have be delineated, and at the back of their minds could well be disclosure levels 'to' the board.

We hope to present to you a series of articles by the author of the piece that follows, as well as by others in the industry, that will throw light on what is happening as far as corporate governance is concerned in the Indian insurance industry, and what should be done.

Ashvin Parekh

The last two years have seen dramatic changes in the insurance industry. Events worldwide have had a substantial impact on the working of the industry and most of its players. Capital has become scarce and most companies have lost values in the market in large quantum. Under these circumstances, it becomes even more important for companies to protect values. A high order of corporate governance and an organisation-wide appreciation of value and reporting is critical.

In a two-part article, an attempt is being made to examine the core aspects of value and reporting in the insurance industry.

This first part lays down the financial and other performance measures that demonstrate value creation for the stakeholders, and discusses in detail the communication of this information. It then goes on to discuss the quality of communication both within the organisation and to the market.

The second part of the article will discuss the emphasis laid by individual stakeholders on the measures and the mismatch arising out of the variance in its emphasis.

It will also examine the value and reporting in the industry in the context of the Indian market and will cover best practices and preparatory work to be done by companies as the market evolves and the investor group gets broad-based.

Fundamentals of Reporting

This first part of the article attempts at identifying the financial and other performance measures that demonstrate value creation for investors and aspects of communication of information to the market in an open, consistent and timely way. It does not advocate increased regulation for external reporting. Instead, it recognises that improved information disclosure is in a company's own self interest.

We have four major stakeholders in each company; the executives, the investors, the analysts and the policyholders. These are immediately concerned about the valuation of the company and the reporting. We do have in addition, the regulator and the society at large, who look at the value and reporting constantly.

Financial and other performance measures

The performance measures in the insurance industry may be grouped under six major areas of performance and governance, namely:

- Strategy
- Customers and Markets
- People and Reputation
- Risk management
- Financial position and
- Financial performance

The measures under each of these areas could be shown as below.

PERFORMANCE MEASURES IN INSURANCE INDUSTRY

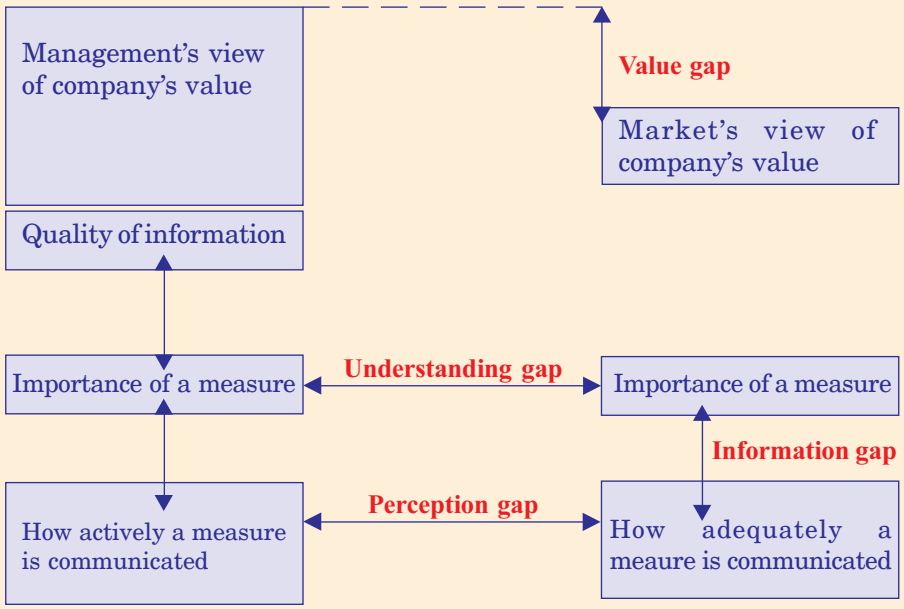
Strategy	Customers and Markets	People and Reputation	Risk management	Financial position	Financial performance
Plans for growth	Customer retention	Quality of management	Risk management practices	Capital management	Express ratio
Distribution channels	Market growth	Employee satisfaction	Asset/ Liability management	Investment performance	Performance by business segment
Product innovation	Customer penetration	Brand Equity	Market risk exposure	Capital adequacy	Earnings
IT expenditures	Market shares	Regulatory reputation	Asset quality	Assets under management	Return on risk-adjusted capital
Degree of diversification				Embedded value	Claims ratio Economic profit Fee-based revenue growth

Gaps in Reporting

Having established the measures across which the governing and reporting can be carried out in the insurance industry, we should examine the emphasis to be placed on each of these. We have four major stakeholders and there will be areas of gaps between these stakeholders with regard to the significance of these measures.

To begin with we may encounter communication problems between companies and the market in five areas. Let us examine these. (See visual)

THE FIVE AREAS OF GAPS



An understanding gap is created by differing perceptions held by companies and the market about the importance of a particular performance measure. When companies assign different degrees of importance to performance measures than do analysts, investors and policyholders, the understanding gap arises.

When the market receives inadequate information about a measure it deems important, an information gap occurs. Analysts and investors will be dissatisfied with insurance company disclosure practices when they receive insufficient information about performance measures that they view as important. When these gaps arise in the disclosures, uncertainty is created in the market. The likely result: a negative impact on stock prices (or reputation) created by higher discount rates for expected earnings and cash flows.

Thirdly, a reporting gap is created when executives make very little effort to report to the market information about measures they deem important for running their company. Why does this happen? One possibility: companies may be providing information to the market, but the policyholders, investors and analysts don't understand how to deal with it. As a result, they may simply focus on a few key bottom-line measures. Another possibility: companies may not report this information at all. This explanation may seem more plausible.

A perception gap is created when companies hold differing views from the market about the value of the information they provide about specific measures. It is evidence of the lack of awareness of a communication problem. A positive perception gap results when companies believe they are providing better information than the market does. Conversely, a negative perception gap is created when the market is more satisfied with the information than companies would expect.

Finally a quality gap is created when management views a particular measure as important but cannot or does not reliably provide information about it on the company's internal reporting and control system. One reason, very unacceptable though, to not report information on the governance of the company and to the market is that a company's internal information systems cannot or do not produce reliable information.

Conclusion

Effective corporate governance of an insurance company would entail examining the quality of reporting, both internal and to the markets, on the performance measures with adequate emphasis. The executives concerned should make regular efforts to strengthen the reporting and bridging the gaps. This calls for a continuous and proactive effort on the part of the executives to survey the information needs of all the stakeholders and make the reporting as open, consistent and timely as required.

The author is Executive Director of Deloitte Touche Tohmatsu. The views expressed here are his own and not necessarily those of his organisation.

LIFE COUNCIL

Mr. P. A. Balasubramanian, Member (Actuary), IRDA, has been made Chairman of the Life Insurance Council of the Life Insurance Association of India.

The position fell vacant on the retirement on December 31, 2002, of Mr. H. O. Sonig, Member (Life), IRDA.

The IRDA Chairman and members will meet with the chief executives of all life and non-life companies in Hyderabad on May 5 and 6 respectively for an annual review.

OMBUDSMAN IN CHARGE

Mr. Achutan Unni, Insurance Ombudsman at Kochi, is officiating as Ombudsman at Hyderabad following the demise of Mr. C.S. Rao, who held that position in Hyderabad.

Mr. Unni can be contacted at:

Office of Insurance Ombudsman
Pulinat Building
2nd Floor, M.G.Road
Kochi - 682 015.

TRACKING INVESTMENTS

The IRDA has asked general insurance companies to file quarterly reconciliation statements between the purchase and sale of investments and Form 3B – which is a status report of total assets – filed for that quarter.

Meant to track the value of investments made by insurance companies on an ongoing basis, the statement is due beginning the quarter ending March 2003 and should be filed within 21 days of the end of the quarter. The process will establish a master list of categories of investments allowed to insurers and this will be mapped into the balance sheet finally.

The statement is to be prepared in line with the major heads of Form 3B like Central Government Securities, State Government and other Guaranteed Securities and so on. The opening balance of each security should be a consolidated entry shown at the weighted average cost (carrying cost) of that particular security or at the actual cost of purchase less amortization.

In the case of mutual fund investments, the opening balance is to be calculated as a product of the number of units held and the weighted average value of the net asset value (NAV) or all purchases made up to that period for each of the mutual funds.

The information relating to purchase and sale of mutual fund units for the quarter shall be the consolidated weighted average cost of each mutual fund.

All purchases made during the period are to be the consolidated weighted average value security wise and be listed as per the various groups listed in 'Category of Investments' under the major heads of Form 3B. The book value shall be the consolidated weighted average value of each security purchased during the quarter.

Similarly the cost of sales shall be the weighted average cost of the investment. The closing balance shall be the sum of the weighted average cost of the opening balance and purchases made during the period reduced by the cost of sales for that period which shall be listed security wise. This will be the investment carried forward to the next period.

For mutual funds units the IRDA has specified that they shall be reported at weighted average cost and that their market value, reflecting the increase or decrease in the NAV shall be mentioned in Form 3B.

LICENSED BROKERS

The following entities have been licensed by the IRDA to operate as insurance brokers for a period of three years. Here is a list of newly licensed brokers with the names of the Principal Officers and contact information.

K.L. Naik
J.B. Boda Reinsurance Brokers Pvt.Ltd.
Maker Bhavan No. 1, Sir V.T. Marg,
Mumbai-400 020
Ph.: (022)56314901 / 56314949
Reinsurance

Nirmal Bazaz
Microsec Risk Management Ltd.
Azimganj House, 2nd Floor,
7 Camac Street,
Kolkata-700 017
Ph.: (033) 22829330

Smita Bharagava
Corporate Risks India Pvt. Ltd.
AM-PRO House, B-45, Shivalik,
New Delhi-110 017
Ph.: (011) 26692800 / 26692954
Composite

Mohamed Rayees
Willis BA Pvt. Ltd.
Commercial Union House, 2nd Floor,
9 Wallace Street, Fort, Mumbai-400 001
Ph.: (022) 22819750 / 51
Composite

M.B. Nagda
Dossa Insurance Services Ltd.
Nanabhai Mansion, 4th Floor, Sir P.M. Road,
Fort, Mumbai-400 001
Ph.: (022) 22664773 / 22653060

Sunil Talwar
Protect Insurance Services (India) Pvt. Ltd.
1007 Raheja Centre,
Nariman Point, Mumbai-400 021
Ph.: (022) 22041140

Sudhir Kumar Jain
Embee Ins. Brokers Ltd.
SCO-1116-17, Sector 22-B,
Chandigarh
Ph.: (0172) 386551 / 386552

Dilip Munshi
PAN Insurance Brokerage Co. Pvt. Ltd.
Transmission House, Marol Coop Ind Estate,
Plot No. 6/19, Compartment No. 82,
Marol, Andheri (East), Mumbai-400 059
Ph.: (022) 26934900 / 26935900
Composite

Sandeep Narain
Hindustan Insurance Brokers Ltd.
25/1-A, Karachi Khana,
Kanpur-208 001(UP)
Ph.: (0512) 2312190, 23000122

Narendra Bansal
Sanguine Insurance Brokers Pvt. Ltd.
B-21, Plot No. 50, Sector 9,
Rohini, New Delhi-110 085
Ph.: (011) 278863320

Arvind Kumar Khaitan
Salasar Services Insurance Brokers Pvt. Ltd.
23A,Netaji Subhas Road, 6th Floor,
Kolkata-700 001
Ph.: (033) 22205856 / 0376

Kapil Rathi
Ashwini Ins. Consultants and Brokers Pvt. Ltd.
208, Kedia Chambers, S.V. Road,
Malad (West) Mumbai-400 064
Ph.: (022) 28818814

Divya Sehgal
EMEDLIFE Insurance Broking Services Ltd.
15A, 15th Floor, Atma Ram House,
1, Tolstoy Marg, New Delhi-110 001
Ph.: (011) 23320613, 23737379

P. Chatterjee
Birla Insurance Advisory Services Ltd.
2nd Floor, Shriniwas House,
Hazarimal Somani Marg, Mumbai-400 001
Ph.: (022) 22058770

K.C. Surati
Raj Assurances
4-5, Swagat Complex, Opp. Sneh Milan Garden,
Near Kadampalli Society,
Nanpura, Surat-395 001
Ph.: (0261) 2464518 / 19

K.K. Sudhakaran
AIMS Insurance Broking Pvt. Ltd.
33/1915, Manimala Road,
Edappally, Cochin-682 024
Ph.: (0484) 2533441

B.K. Sinha
Unison Ins. Broking Services Pvt. Ltd.
608-609, "Siddharth", R.C. Dutt Road I
Alkapuri, Baroda-390 007
Ph.: (0265) 2357445 / 2357446 / 2325048

J.N. Kapil
Probus Brokerage Ltd.
124, Anupam Garden, Manekshaw Road,
New Delhi-110 068
Ph.: (011) 26521101, 26528162

K.P. John
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1103, Raheja Centre, 11th Floor,
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Mumbai-400 077
Ph.: (022) 25093509 / 10 / 11
Composite

Sanjiv Dhobal
R.R. Brokerage Assurance Services Pvt. Ltd
412-422, Indraprakash Building,
21, Barakhamba Road, New Delhi-110 001
Ph.: (011) 23352496-97-98-99
Composite

FINED

The IRDA has levied a fine on Reliance General Insurance Company Limited for not fulfilling its obligations towards rural sector business in the financial year 2001-2002.

The company, which started operations on March 27, 2001, was required to produce business from the rural sector to the extent of two per cent of the total direct gross premium income written in the first financial year of its operations and three per cent in its second year.

While the company has fulfilled its obligations with regard to social sector business, it has not procured any business from the rural areas in either year. Since it was in operation only for four days in the first accounting year its rural and social sector obligations for that period were waived, but in respect of the second financial year or 2001-2002, the company said that this was because it had not set up any infrastructure facilities or recruited agents in the rural areas.

The IRDA did not find this reason acceptable as the company was fully aware of its obligations under Section 32B of the Insurance Act and the IRDA (Obligations of Insurers to Rural and Social sector) Regulations, 2000.

Hence the IRDA, which is empowered to levy a fine of up to Rs. five lakhs under Section 105B of the Insurance Act, for not conforming to the provisions of Section 32B of the Act and the regulations, has levied a fine of Rs. two lakhs on the company considering that it was in its first year of business.

Pensions Conference

The Institute of Insurance and Risk Management (IIRM) in association with the Organisation for Economic Co-operation and Development (OECD) and the International Network of Pension Regulators and Supervisors (INPRS), is holding a two-day conference on Pensions on May 29 and 30 at Hyderabad. Entitled the OECD/INPRS 2nd Conference on Private Pensions in Asia, it is to be co-chaired by Mr. N. Rangachary, Chairman, IRDA, and Mr. Ambrogio Rinaldi, COVIP, Italy, Chair of the OECD Working Party on Private Pensions.

The conference is meant for select invitees only.

The first session after the inauguration will be on **Structural Design and Management of Defined Contribution (DC) Programmes**, moderated by David Lindeman of the OECD.

The following speakers have confirmed their participation in this session.

Use of insured pension products in different DC pension regimes – Michael Orszag, UK, Clearinghouse – E. Palmer, Sweden, Migrating to Individual Choice – Mukul Asher, Singapore and Employer plans with worker choice – Stuart Brahs, Principal Financial Group, the US.

The second session will be on **Disclosure, Education and Financial Literacy and Their Role in Pension Plan Participation and Investment Decisions** and it will be moderated by Mr. Greg Brunner, APRA.

The speakers for this session will be Mr. Edward Whitehouse, UK, Mr. Gautam Bhardwaj, India and Mr. Roslan Gaffer, Malaysia

The session on **Investment Strategy** will be moderated by Mr. Roslan Gaffar, Employees Provident Fund, Malaysia.

On May 30 the first session will be on **Product Design and Marketing.**

The speakers for the session will be Mr. Mike Orzag, UK, TBC and the discussion will be led by Mr. Kapil Mehta, Max New York Life, the US.

The session on **Coverage and Participation Rates in DC plans** will be moderated by Mr. Mario Gabriel Budebo, CONSAR, Mexico.

In this session, there will be a discussion of the various proposals for extending coverage to the unorganised sector in India through voluntary DC schemes.

Speakers in this session include Mr. Subedar, Advisor, Prudential India on the challenges in India, TBC (OASIS and IRDA proposals), Mr. A.P. Singh, Director (Financial Services), Department of Posts, TBC (on the role for widespread outreach and distribution in achieving coverage) and Mr. Edward Whitehouse, UK on tax incentives. The discussion will be lead by Mr. Suwatana Sripirom, Thailand.

The session on **Reform of Occupational Pension System in India** will focus on the situation in India. Currently, the Government of India is re-examining the existing pension system for organised private sector workers as well as for civil servants. During this last session, speakers from India will outline their country's current pension system and the agenda for changes to it. The leading discussants for this session will be Mr. N.K. Shinkar, Consulting Actuary, IRDA, and Mr. Esperanza Lasagabaster, World Bank.

The last session is on **Indian Regulatory Reform: Supervisory Considerations** to be moderated by Mr. Vinicius Pinheiro, OECD. This session will examine the supervisory issues that one must consider when shaping regulatory reforms. One of the discussants will be Mr. Greg Brunner, Australia.

On May 28 the Asia-Pacific Regional INPRS Meeting will be held. The meeting will be chaired by Mr. N. Rangachary, Chairman, IRDA, and the topic of the meeting will be **Supervisory Structure and Techniques.**

IIRM Starts

The Institute of Insurance and Risk Management (IIRM) will commence its first study programme in the third week of May in Jakarta, Indonesia.

The one and a half year International Post Graduate Diploma in Insurance and Risk Management will be conducted jointly with the United Nations Committee for Trade and Development (UNCTAD) and will have Indian, European and Asian faculty. The course is being run in co-operation with the Indonesian insurance regulator.

Ms. Maizon Omar, till recently Director, Malaysian Insurance Institute (MII), Kuala Lumpur, has taken over as Chief Executive Officer, IIRM, and Mr. J. S. Kumar, who was Senior Manager at the MII has taken over as its Chief Operating Officer and Director.

Other international study and research programmes are on the anvil said Mr. Kumar, and they will be on Risk Management, Insurance, Financial Planning and Pensions.

The IIRM will work closely with the Institute of Actuaries of India and the Insurance Institute of India. It has plans to hold study, research and short-term programmes with Indian and international faculty. Courses will be held in association with UNCTAD, OECD, World Bank, the International Association of Insurance Supervisors and the International Insurance Foundation.

The IIRM recently conducted successfully at Delhi, it's third Emerging Markets Conference which was well attended and received.

It operates out of: Plot No: 310, Road No 25, (Near Obul Reddy School and Marri Chenna Reddy Institute), Jubilee Hills, Hyderabad – 500 033.

Phone: 040-23556470, Fax: 040-23556471, e-mail: email@iirmworld.com.

Report Card: LIFE

Analysis of new business underwritten by life insurers for the financial year 2002-03.

The year 2002-03 marked the end of the third financial year for the private sector life insurers. During the year, Aviva Life was the lone new entrant in the life segment, thereby taking the number of insurers doing life business to 13, inclusive of the monolithic public sector Life Insurance Corporation of India (LIC).

The year witnessed tremendous growth in terms of private insurers adding new business to their portfolio. However the overall new business premium witnessed a decline vis-à-vis the financial year 2001-02, as the impact of declining interest rates in the economy percolated down to the insurance sector. With the interest rates moving southwards, the insurers slowly withdrew policies with guaranteed returns. Overall the decline in new business was 18 per cent with premium underwritten at Rs. 12,32,483.37 lakhs as against Rs. 15,13,993.75 lakhs in the previous year.

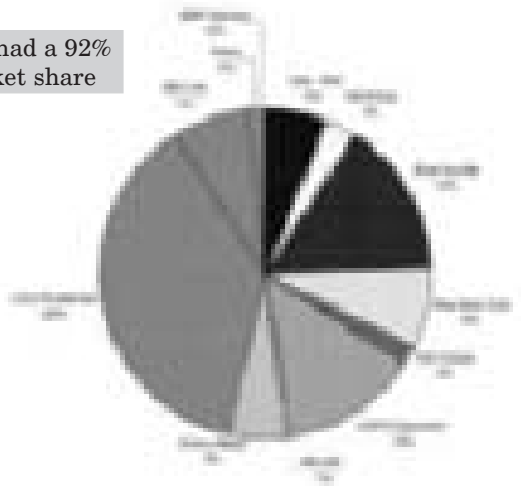
Performance of LIC

The business of LIC of India was impacted the most with the individual business (inclusive of Bima Nivesh and Single Premium) exhibiting a decline of approximately 24 per cent at premium underwritten of Rs. 9,36,111 lakhs. Similarly individual pension plans exhibited a decline of 87 per cent at Rs. 32,775.64 lakhs. Interestingly the number of individual assurance policies showed an increase of 9.54 per cent over the previous year at 2,39,31,247.

As against this, the pension and group schemes exhibited a growth rate of 65 per cent with new business premium of Rs. 1,64,574 lakhs covering 18,48,428 lives. The growth in this sector was the highest recorded in the last ten years. In the social sector, under the Janashree Bima Yojana and the Krishi Shramik Samajik Suraksha 7,46,129 lives were covered under 6,071 schemes

NEW BUSINESS MARKET SHARE 2002-03
PRIVATE LIFE COMPANIES

LIC had a 92% market share



New Business Premium 2002-03 (Provisional)

(Rs. in lakhs)

S.No.	Insurer	Premium	No. of Policies	Mkt. Share %
1	**Tata AIG**	**5,975.22**		**0.48**
	Individual business	4,685.73	91,500	
	Group business	1,289.49	68	
2	**OM Kotak**	3,068.33		**0.25**
	Individual business	2,987.11	32,247	
	Group business	81.22	3	
3	**Birla Sunlife**	14,956.90		**1.21**
	Individual business	12,627.60	64,758	
	Group business	2,329.30	86	
4	**Max New York**	7,681.07		**0.62**
	Individual business	7,535.31	74,199	
	Group business	145.76		
5	**ING Vysya**	1,747.00		**0.14**
	Individual business	1,740.70	26,663	
	Group business	6.30	1	
6	**HDFC Standard**	13,266.21		**1.08**
	Individual business	12,876.43	1,24,837	
	Group business	389.78	2	
7	**MetLife**	620.09		**0.05**
	Individual business	616.72	11,225	
	Group business	3.37	2	
8	**Allianz Bajaj**	5,378.39		**0.44**
	Individual business	5,347.66	1,15,951	
	Group business	30.73	13	
9	**ICICI Prudential**	36,494.40		**2.96**
	Individual business	36,295.00	2,44,434	
	Group business	199.40	4	
10	**SBI Life**	7,275.16		**0.59**
	Individual business	5,306.00	17,440	
	Group business	1,969.16	306	
11	**AVIVA**	1,261.06		**0.10**
	Individual business	1,253.25	17,023	
	Group business	7.81	1	
12	**AMP Sanmar**	460.42		**0.04**
	Individual business	387.37	16,344	
	Group business	73.05		
	PRIVATE TOTAL	98,184.25		
	Individual business	91,658.88	8,36,621	
	Group business	6,525.37	486	
13	**LIC**	11,34,299.12		**92.03**
	Individual business	9,68,886.85	2,45,29,946	
	Group business	1,65,412.27	15,637	
	GRAND TOTAL	**12,32,483.37**		
	Individual business	**10,60,545.73**	**2,53,66,567**	
	Group business	**1,71,937.64**	**16,123**	

garnering premium income of Rs. 837.68 lakhs, marginally lower than the figures for the previous year.

The market share of LIC in the new business underwritten was 92 per cent in the financial year 2002-03, as against 98 per cent in the previous year.

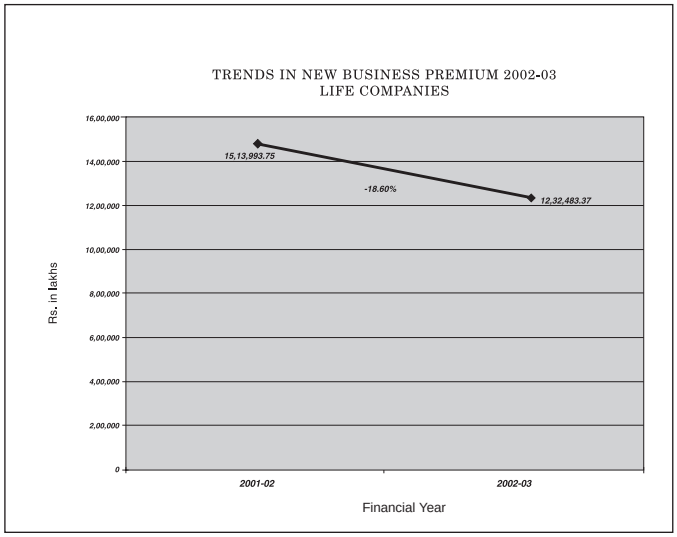
Performance of Private Sector Insurers

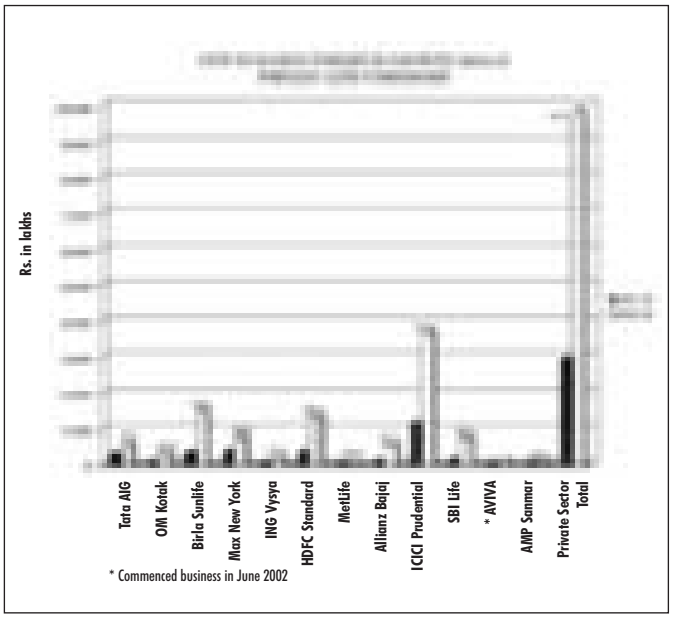
An analysis of the new business figures furnished by the insurers reveals that overall business captured by the twelve companies grew to Rs. 98,184.25 lakhs from Rs. 29,661.68 lakhs, exhibiting an increase of 231 per cent. Overall the private insurers' market share increased from two per cent in the year 2001-02 to eight per cent in the financial year 2002-03. ICICI Prudential captured nearly three per cent of the new business underwritten, followed by Birla Sunlife and HDFC Standard at 1.21 per cent and 1.08 per cent of the premium underwritten. In terms of number of policies, while ICICI Prudential had issued approximately 2.45 lakh policies, HDFC Standard and Allianz Bajaj followed with 1.25 lakh and 1.16 lakh policies respectively (Allianz's market share in terms of premium was 0.44 per cent).

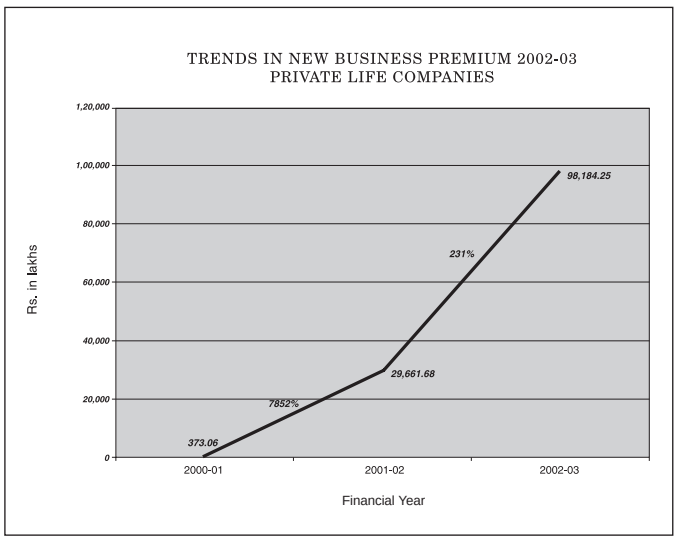
In terms of premium underwritten in rural sector, SBI Life led with premium underwritten at Rs. 504.21 lakhs, followed by MetLife at Rs. 215 lakhs. In terms of number of policies underwritten in rural sector, ICICI Prudential led with 29,376 policies.

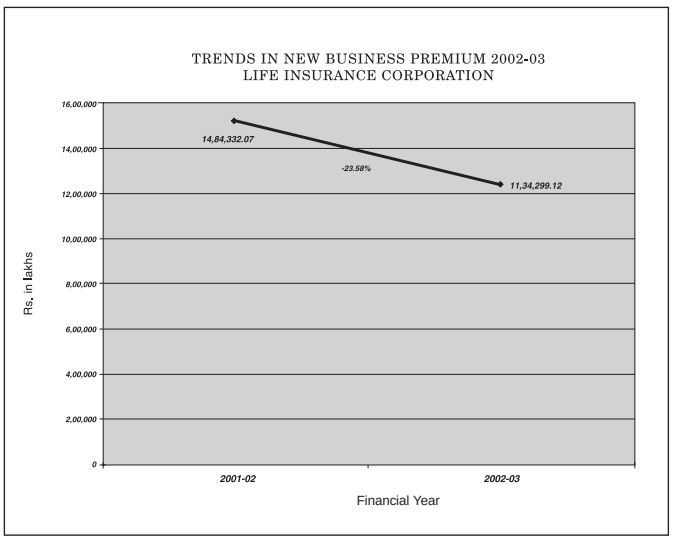
In the social sector, SBI Life again led with premium of Rs. 39.45 lakhs and lives covered at 37,478 lives.

PREMIUM GROWTH TRENDS 2002-03



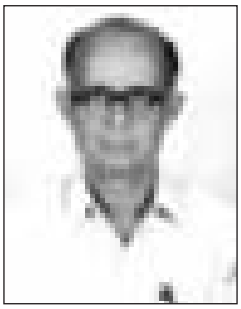






A Matter of Concern

R. Desikan



Even though I have been a holder of one insurance policy or another all my life, I have never had as much exposure to the insurance industry as in the past ten years. The depth of knowledge I have acquired during the past decade through intervention as a consumer activist is something that is very useful not only to me but to all the citizen- consumers of insurance services in India.

The very first complaint I came across in this sector was against LIC Housing Finance Ltd. Briefly, the complaint was about the usurious interest charged by LIC Housing on delayed payment of installments due on housing loans.

Let us say that you had borrowed Rs. One lakh from LIC Housing Finance and had agreed to 32 half yearly installments of Rs. 3,000 and odd. Let us say you have been a regular payer for 10 installments leaving a balance of 22 installments. You delay the 11th installment by a few weeks. They tend to forgive you. But if you delay the 12th installment also by four weeks, you will be charged punitive interest, not on the installment due but the entire amount due from you for the 21 remaining installments!

When this was brought to my attention, I took the matter up in the consumer disputes redressal forum. It was argued by the LIC counsel that the borrower had signed accepting the terms and conditions as laid down by LIC Housing. I argued that whatever punitive interest the company wanted to levy, they were entitled to it only for the overdue installment and not for the entire residual balance of the loan amount.

We proved that the interest charged in the manner laid down by LIC Housing meant that an unfortunate delayed payment would attract more than 3000 per cent interest, which is, to say the least, usurious. I had to quote a decision of the Privy Council of the UK, which is still quoted for comparable decisions, that any contract between unequal parties is void.

Whatever was the outcome of the consumer forum's decision, I must say to the credit of LIC Housing that they changed the rules. I mention this to point out how thoughtlessly rules are framed, without taking into account fairness to the consumer.

When I had the privilege to serve on the committee for the revision of the Motor Tariff - the Ansari Committee – I found the knowledge and attitude of the public sector insurance companies, to say the least, very poor.

> When I analyse the problems faced by consumers, it is clear to me that they basically stem out of a lack of concern for the consumers' needs of honesty, transparency, clarity and friendliness.

The entire industry wanted a revision of the tariff without producing statistics to justify the claims for an upward revision!

Thus having been exposed to various situations where the consumer-policyholder is left holding the bag, when I analyse the problems faced by consumers, it is clear to me that they basically stem out of a lack of concern for the consumers' needs of honesty, transparency, clarity and friendliness.

Such complacency had perhaps arisen because of the nationalisation of the insurance sector, but I would not say that nationalisation alone is the cause.

The lack of accountability of the CEOs and the management, their own reduced delegation of powers, their promotions being tied to political connections, audit objections if a claim is settled quickly (or employees' perception of this as a possibility), the unsolicited abdication of responsibility of officers to unions and the misuse of that as an excuse for a lackadaisical attitude and, in some instances, the interference of union office-bearers in condoning mistakes and irresponsibility, were all the real causes for the consumer-policyholders being neglected.

Unfortunately, in spite of starting to lose huge business to the private companies that have entered the insurance sector, the attitude of the public sector companies does not appear to have changed.

What do I and millions of citizen-consumer policyholders expect from the insurance industry?

- Courteous service
- Clarity about the benefits a policy promises
- Clarity about what the policy does not promise
- How long it will take for the insurance policy issuer to settle a claim
- What documents are needed to settle a claim and whether this information can be asked to be provided completely and in one go and not over several weeks and months of correspondence between the company and the policyholder

In addition to the above:

1. Can the time limit set for settling/ refusing a claim by the IRDA, of 30 days, be made known to every policyholder on the day the policy is issued?
2. At the time of renewal, can the consumer be informed at least a fortnight ahead and some sort of personal contact established so that

answers to any question of the consumer is given?

3. In a Mediclaim policy, can the consumer be very clearly told in writing the exclusions even as the business is being solicited?
4. When a bulk business is secured, the insurance company does not keep in touch with the consumer-policyholder. I would recommend that each policy is assigned to an agent or development officer, even though commission may not be paid.

In case of motor vehicle accidents, it is necessary that some kind of contact is kept with police officials, media, hospitals etc. so that the next of kin is met, condolences offered and support extended, instead of the current practice of waiting for a claim to be filed. In such cases invariably it is filed by an ambulance chasing lawyer who gets most of the compensation while the victims' family gets next to nothing.

It would do the industry a lot of good to develop a common pool of information and data on accidents so that quick relief is given instead of allowing the courts to order huge amounts totally unrelated to the financial conditions of the victim.

Quick disposal will reduce claim payments; reduced claim payments will increase the profitability; increased profitability can reduce the premium; reduced premium can draw more business.

Quick disposal will reduce claim payments; reduced claim payments will increase the profitability; increased profitability can reduce the premium; reduced premium can draw more business.

The attitude of most public sector companies has so far been –'let the courts decide,' on third party claims. This has led to bleeding of the public sector insurance companies, or so they claim. What efforts have these companies put in to lobby for change in the Motor Vehicles Act or rules?

In every situation in life there are two possibilities.

- Finding reasons why a situation cannot be handled and solutions found to problems and
- Finding ways to find a solution.

For too long the insurance industry has been following the first option. If the public sector insurance companies have to become consumer friendly and supportive, it is time they removed the first option from their agenda and followed the second option.

The author is a consumer activist and Trustee, Consumers' Association of India and CONCERT (a centre for consumer education, research, teaching, training and testing).

GOOD AND BAD

We welcome consumer experiences.
Tell us about the good and the bad you have gone through and your suggestions. Your insights are valuable to the industry.
Help us see where we are going.

Send your articles to: Editor, IRDA Journal, Insurance Regulatory and Development Authority,
Parisrama Bhavanam, III Floor, 5-9-58/B, Basheer Bagh, Hyderabad 500 004 or e-mail us at irdajournal@irdaonline.org

For Informed Decisions

R. C. Sharma

Life was relatively simple when we had only one choice for buying life insurance, and virtually only one choice for non-life insurance! Though other problems were there with buying the covers, there was no difficulty in deciding what to buy – you bought whatever was offered!

But faced, as we are today, with half a dozen companies offering a range of products that we are free to choose from, we realise how true it is that freedom has its responsibilities.

Responsibilities are for both parties – the insurer and his prospective customer. And underlying that is information.

To be able to make an intelligent choice of suitable insurance products today, customers have to have unbiased and purposeful information. It is here that advertising of insurance grows from being mere enticement to an act of advice and communication from the insurer to his prospect.

And when you think of how insurance is bought to safeguard a person's assets, his future and that of his family, responsible information is not merely power, it is the very basis of survival.

The IRDA (Insurance Advertisements & Disclosures) Regulations, 2002, read along with IRDA (Protection of Policyholder's Interests) Regulations, 2002, and various circulars issued by the Authority on the 'File and Use procedure' for insurance products reveal how the information is required to be disseminated to the prospect. How it has to be chiselled into being precise, relevant and transparent to the end user.

We need not belabour the point of protection of policyholder's interest as that is central to the protection of insurers' interests as well. The central objective of the regulations cited above is to make sure that the consumer is neither misguided nor dodged at any point of time.

Every advertiser is supposed to adhere to the recognised standards of professional conduct as prescribed by the Advertisement Standards Council of India (ASCI). IRDA regulations complement these by adding some preventive and corrective measures. But the ultimate protection for the consumer will be the code of conduct that insurers have to follow with regard to disclosure of information.

Yet, the provisions of the IRDA (Insurance Advertisement and Disclosures Regulations), 2000, is a big step to bridge the gap between what can be done and what is being done in the area of appropriate advertising.

The ultimate protection for the consumer will be the code of conduct that insurers have to follow with regard to disclosure of information.

Before we go to what the regulations provide for, we must remember that the present trend of aggressive marketing cannot leave insurance marketing managers unruffled and the fast-changing style of advertisement aiming at 'pulling consumers' in is bound to influence them while conducting their own advertising and marketing of insurance products and services.

Thus it is for the consumer to properly weigh the insurance product, analyse prudently its utility and short-term and long-term benefits to himself.

This is where the IRDA (Advertisement and Disclosure) Regulations, 2000, help the consumer from the back stage, by ensuring that his opinion about a particular product is guided by the disclosure of complete facts.

The consumer should use this information to acquaint himself with the details of the proposals before entering into any transaction and should also be cautious and adopt different ways like the following to guard himself.

- The consumer has to beware of semantic camouflage which may try to hide the real facts about the product
- He has to look at the authenticity of the issuer of the advertisement
- He has to gauge if the information provided is complete, clear and fully comprehensible particularly with regard to riders and exclusions
- He has to be aware of whether adequate emphasis is laid on providing after-sales service

What to reveal, how much to reveal and whom to reveal it to have been matters of great apprehension for insurers and their intermediaries. In today's competitive market, complete and accurate information is a must and, in a way, it will create a level playing field.

The IRDA regulations clearly define and elucidate as to what is insurance advertisement and through which media it can be released.

According to the regulations, 'Insurance Advertisement' is any communication directly or indirectly related to a policy and intended to result in the eventual sale of a policy to the members of the public. It includes all forms of printed and published materials or any material using the print and/or electronic medium for public communication such as:

- newspapers, magazines and sale talks
- billboards, hoardings, panels
- radio, television, website, e-mail, portals

- representations by intermediaries
- leaflets
- descriptive literature/circulars
- sales aids flyers
- illustrations from letters
- telephone solicitations
- business cards
- videos
- faxes, or
- any other communication with a prospect or a policyholder that urges him to purchase, renew, increase, retain, or modify a policy of insurance

It also elaborates on who are the authorised agencies/sources who can advertise, like insurance companies, insurance agents or any licensed intermediary.

The regulations also stipulate that every insurance entity releasing advertisements has to have a compliance officer responsible for overseeing the advertising programme.

A copy of each new advertisement or an amendment to the old one has to be filed with the Authority as per regulations.

Every advertiser has to identify himself in the advertisement. Third party involvement for the sake of soliciting and procuring business is strictly prohibited.

When advertisements conform to these regulations the consumer is on his way to the following advantages.

- It is a source of self-protection for the policyholder
- It helps him know the status of the competitiveness of the insurance companies in a liberalised insurance market
- It helps him in judging the proposed schemes
- It leaves very little scope for insurance entities to conceal facts or give misleading advertisements
- It helps in making a comparative study of the insurance products/ services particularly long-term policies
- It is a measure for gauging the strength and soundness of insurance activities

Above all it helps in creating an atmosphere of openness and transparency, where the scope for creating illusions is minimised and the usage of information is optimised.

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

PUBLIC GRIEVANCES

The IRDA had constituted in December, 2002, a public grievances cell to help the insuring public to follow up the issues they had pending with any insurance company. Here is a summary of the complaints received by the cell and their status.

SUMMARY OF COMPLAINTS RECEIVED BY THE AUTHORITY (1/12/2002 TO 21/4/2003)

Total No. of Complaints	**565**
Company	188
Individuals	377
Department-wise Distribution	
Fire	36
Marine	15
Mediclaim	154
Janata Personal Accident	18
Motor	99
Miscellaneous	243
Type of Complaint	
Non-settlement/ delay in settlement of claim	328
Wrongful repudiation of claim/ Settlement of claim for lower amount	56
Non-renewal/cancellation / non-issuance other issues related to policy	151
Unhelpful/ wrong attitude of Officials	11
Other reasons	**19**
Action taken	
Action taken & matter closed	94
Letter acknowledged & reply awaited	246
No response	225

STATE-WISE DISTRIBUTION

Andhra Pradesh	36
Assam	12
Bihar	4
Chattisgarh	1
Delhi	67
Goa	7
Gujarat	19
Haryana	16
Himachal Pradesh	2
Jammu & Kashmir	3
Jharkhand	8
Karnataka	14
Kerala	7
Madhya Pradesh	25
Maharastra	136
Orissa	9
Punjab	10
Rajasthan	19
Tamilnadu	36
Uttar Pradesh	39
Uttaranchal	1
West Bengal	45
Others	49
Total	**565**

Data Management and Detariffing

Anup K. Mathur

The first part of this article, carried in IRDA Journal, April 2003, discussed the significance of data mining and data warehousing to the general insurance industry.

This is the second and last part of the article and discusses how data warehousing and data mining impact key business areas like Actuarial work, Underwriting, Risk and Policy Management and its relevance to the debate on detariffing, particularly with reference to the general insurance market.

Risk modelling is inherent to the business strategy of an insurance enterprise. The amount of data required by the actuaries should be sufficient to reveal a pattern allowing them to establish statistical and mathematical basis for analysis for product development, rating models and pricing mechanism, conduct a what-if analysis, profitability analysis and aid reinsurance decisions. The challenge lies in determining the near to correct pricing of a particular product for a prospect market.

Another area is to develop a representative class of products/portfolio across geographical locations for arranging re-insurance. This step will contribute to lowering re-insurance costs. Trend analyses will reveal what products will be required across a particular class of customers/geographical regions.

Again, data for analysis is spread across various databases in different applications. Unless you have data management tools, it will not be possible to analyse the data.

There is a growing realisation that insurers need to shift towards predictive risk modelling as a business strategy rather than undertaking a mid-course correction through historical analysis of past performance. Hence, the reliance on data management through technology.

Data analysis will reveal some interesting hidden patterns for insurers and re-insurers.

Data analysis would leverage on:

- Trend analysis of loss ratios
- Risk mapping
- Geographical accumulation
- Loss exposure analysis including measurement of loss severity and frequency
- Product usage at a particular pricing
- Changing social milieu, investment patterns, savings patterns across locations, climatic changes, socio-economic changes
- Claims history for a particular risk class e.g. loss ratios of vehicles insured in a particular income/ age group

This analysis will assist insurers in acting proactively and not reactively post-event as is seen now with the terrorism risk modelling, that is in the process of evolution. To be able to immediately spot trends, adopt course corrections and launch appropriate products would assist in achieving greater profits. A consolidated view of past and present events allows the organisation to respond naturally to evolving business needs.

Underwriting is another area which can benefit from a rich, vibrant, dynamic and integrated data source enabling the underwriters to make a well-informed decision. A data warehouse with a data mining and analytic capability would be an aid to the entire underwriting and rating process. Relationships and hidden patterns emerging from the analysis of data will aid the underwriting of risks.

The insurance industry in India has already witnessed chaos in the aftermath of marine detariffing. What followed was a cross-subsidisation of marine products along with the other tariff products. The tariff products could not be cross-subsidised since the tariff was in place. Even today marine business is underwritten without any underwriting basis as the market conditions have dictated some of the players to continue the cross-subsidisation!

Underwriting is no longer an 'art' that only a few people can practice. It has evolved into as much a 'science' as any other 'scientific' discipline though many people may still not accept the fact that there are scientific principles on which underwriting is practiced. Someone actually said that an underwriter should have foreseen the possibility of an incident like the WTC …. Imagine!!

This is because the number of different factors that need to be taken into account before an underwriting decision can be taken is large. Let us consider a simple case in Marine insurance: the risk of transit of cargo from one place to another. The factors that need to be examined are: the nature and characteristics of the cargo, the mode of transit, the method of packing, loading and unloading conditions, weather at the place of origin, during the adventure and at the destination, whether there are transshipments and storage, and whether the transit is multi-modal.

Let us take just one of the factors: weather conditions during the transit. If the transit is on high seas the amount of information that is available on the changing weather conditions throughout the transit is very high and we are not utilising this information to analyse the risk. A high level of simulation of weather conditions is required if we need this information.

Let us consider a few questions: What is the frequency and severity of occurrence of fire in the boiler section of a thermal power plant during a shut down or a start up phase? Is there a co-relation between the two events and the fire outbreak? Is this phenomenon related to the make/ manufacturer/capacity/retro-fit/repair of the boiler? What was the duration of the fire and the related quantum of damages? What improvements are required in the capacity of the fire extinguishing appliances installed in these sections? Is any design improvement required?

In Marine insurance, which commodity when shipped as cargo has suffered damages on a particular sea route? Has a risk mapping been done for a particular sea or inland route for accidents such as stranding, sinking or collisions? An underwriter would like to know the relationship between the nature/ frequency/quantum and severity of marine losses occurring at the port while cargo is awaiting shipment for an outward/inward journey to the average time taken for loading/ unloading.

In Health or say Mediclaim insurance (as in India), an enterprise would be interested to know the claim (treatment) costs by dimensions of disease, sickness, injury, hospital, doctors, geography and

demography, age of the insured, channels etc. The list of queries is endless.

Answers to these questions are some of the challenges that insurance companies face while determining the price for a product and arranging re-insurance.

Similarly, information can be collated into a risk model for all the other risk factors. This information can then be utilised across the enterprise for underwriting, rating and product development and re-insurance. This aspect plays a significant role in the overall business model of the company. It is necessary to project a comprehensive seamless risk model. The challenge lies in determining the near to correct pricing of a particular product for a prospect market. It is particularly this area that needs to be strengthened today if the companies have to think about detariffing.

Perhaps the industry was not prepared to detariff the Marine portfolio a few years back as it did not have a consolidated data and risk model. This is one area that has to be looked at seriously by the public sector unit (PSU) insurers if they want to stay ahead of the competition and survive. The irony of the matter is that it is these very companies that possess a rich source of data that spans across their various operational offices in the country.

Similarly, life insurance companies would like to know the real causes of policy lapsation. Access to important parameters like product usage history, claims history, customer wallet, social and personal habits, saving pattern and income group is critical for any life insurance company. The insurance industry is in the midst of witnessing a shift from customer relationship management to customer value management that has to be collaborative and consistent.

BUSINESS Intelligence Reports

Business intelligence reports based on different dimensions for Analysis Modelling, Product Development and Pricing

- Industrial classification-occupation, processes, industry, cause of losses, construction, area (property, casualty, liability) etc
- Motor vehicle type, make and model, usage, ownership, geographical area and location, age-wise usage and loss history-age, vehicle and usage dependency
- Appreciation and depreciation rates for multiple classes of property
- Risk exposures by class of business and product limits
- Claims frequency and severity forecasting-LoB (line of business), product, channel etc
- Mean claim amounts and loss ratios-LoB, product, channel demographic distribution of losses etc
- Claims estimation and assessment-product, LoB, risk, peril, industry channel, etc
- Market loss ratios – product, LoB, YoY, channel, peril, industry etc
- Loss trend/experience analysis-customer, YoY, location, region, process, construction, vehicle type, make and model
- Claims history-risk-wise/cause of loss wise, product-wise etc
- Loss assessors and adjusters analysis
- Underwriting costs of property and casualty by line of coverage and product
- Self insured retention and deductible analysis
- Incident and action reporting
- Critical pathways
- Concurrent review
- Custom reports library
- Litigation tracking
- Discounted cash flow analysis
- Loss reserves tracking and evaluation of insurance and reinsurance programmes-LOB and product, risk
- Loss development through simulation and risk mapping
- Customer profiling and segmentation: age range, income range, average household income range, consumer spend range, customer life cycle, customer expectation, product need and usage, cross selling, health analysis, social and personal habits, annual savings and investment pattern, transactional preferences, product usage as per line of business, customer retention
- Geographical and catastrophe regions-risk mapping, accumulation and zoning e.g, earthquake, flood, tornado, cyclone, volcanic eruptions etc. aggregation and segregation modelling
- Loss assessment and settlement analysis
- Aggregation of risks/perils/sums insured
- Segregation of risks and sums insured
- Trend analysis of loss/risk/catastrophe
- Catastrophe loss analysis
- Claims transactional analysis
- Fraud detection
- Managed healthcare organisations and service providers analysis-quality, quantity, necessity, cost of medical service, hospitals, pharmacy, medical bills and information of physician
- Socio-economic conditions and product features and pricing
- Product development and premium pricing: sales history patterns, business potential, geographic variances, risk reduction, loss ratios

Underwriting operations

- Tracking and management of insured/proposed subject matter
- Property, fixed assets and moveable by location, unit, subunit, ownership, exchange rate fluctuation, enhancements
- Mid-course policy corrections
- Estimated life, improvements, inspections, risk assessments, ratings by date, recommendations
- Value: depreciation, improvement,
- Certificate issuance and management

Reinsurance

- Inward/outward placements
- Risk exposure-class of business and limits
- Cost
- Retention-line of business, product
- Treaty-compulsory/surplus
- Cessions, co-insurance, lines etc
- Facultative costs/exposure
- Claims-LOB, product

Profitability Analysis

- Product, line of business,
- Geographic location
- Agency lines
- Customer segment

Customer Life Time Value needs to be determined for increasing the wallet share. Opportunities for up-selling and cross-selling need to be explored. A seamless, company-wide access to detailed account data will enable a sales person to facilitate co-ordination between sales, underwriting, risk managers, customer service and support as well as marketing personnel for a unified approach. An instant access to all communication, including e-mail, notes, calls and resolutions will assist in customer management and customer relationship development across the organisation.

Today, insurance buyers have many more options for purchasing insurance and interacting with their insurance suppliers. They can work through agencies. They can work directly through insurance companies or brokers. They can purchase insurance through online sites or exchanges.

Customer focus for an insurance company is important. Getting closer to customers and effectively responding to their needs is required to boost loyalty and encourage deeper business relationships. It may also lead to capitalising on creating opportunity for additional spending by the customers. Increasing share of the customer wallet is as strategic as cutting costs and improving efficiency.

This new business climate has elevated the role of customer relationship management (CRM) technologies into a highly strategic position within the insurance industry. CRM technology focuses on managing all interactions that the organisation has with its customers, maintaining contact information and customer status in order to leverage the data in a variety of business applications.

Data mining can draw information from a database of customer information to pinpoint customer behaviour. A customer relationship application built on

Premium Mapping
- Location-wise
- Zone-wise
- Branch-wise
- Line of business
- Channel-wise
- Product-wise
- Underwriting or calendar year
- New business/renewal/both
- Corporate/renewal
- Major clients
- Major channels

Customer Profile Mapping
- Customer name
- Customer age
- Address
- Phone numbers
- Email
- Customer products mapping/usage
- Age range
- Income range
- Average household income range
- Consumer spend range
- Customer life cycle
- Customer expectation
- Product need and usage
- Cross selling
- Health analysis
- Social and personal habits
- Annual savings and investment pattern
- Transactional preferences
- Product usage as per line of business
- Customer retention
- Client profitability by clients/DSA/ product
- Other details

Performance Analysis – Location-wise, Branch-wise, Zone-wise, Channel-wise
- Type of product
- Line of business
- Dealer from whom the asset has been purchased
- Colour/age/make/manufacturer of the product
- Premiums
- Commissions paid
- Insurance details
- Insurance claims
- Previous insurers
- Customers
- Gross written premium
- Premiums due
- Commissions paid
- Premiums receivables
- Claims reported
- Claims outstanding
- Claims paid
- Gross margins
- Net premiums
- Claim amount
- Others

Dealer/DSA Mapping – Location-wise, Branch-wise, Zone-wise, Channel-wise
- Products sold
- Type of products
- Insurance details
- Number of deals done
- Total revenue generated
- Documentation
- Number of claims processed/ settled
- DSA sales
- Number of closures achieved
- Sales target v/s plan

Claims
- Claims by year of manufacture
- Claim count/ registered/ paid
- Claims-Above a specified amount per line of business, product, class etc
- Loss ratio by year of manufacture/make/ model type etc
- Claim-size per policy
- Claims outstanding + paid
- Incidence of Claim on Earned Policy (frequency ratio)
- Ageing analysis of claims as 1-3 months, 3-6 months, 6-1 year, 1yr +
- Cause of loss analysis LoB, product etc
- Response-time analysis
- Motor-labour and parts ratio
- Motor-claim size per claim
- Motor-claim size per policy
- Motor-claim size frequency
- Motor-make/age/modelwise profitability
- Cause analysis
- Loss ratio on gross/net basis
- Claim size
- Workshop
- Surveyor
- Office
- Channels
- Slabs of (in Rs.)
  - 0 – 5,000
  - 5,000 – 15,000
  - 15,000 – 50,000
  - 50,000 – 1,00,000
  - 1,00,000+

a data warehouse would arm the agency force with timely information on customers and prospects that need to be approached for sourcing business. This will help the agents improve productivity and earnings. The company will be in a position to increase business and win and retain the loyalty of its agents. A competitive edge is therefore created and maintained.

Customer affinity and requirements will determine innovation and development in the products. It is another area of an enterprise that relies heavily for support on the data warehousing and data mining techniques. Which products to be launched? What is the target group? What price? Which geography should the company target for a specific product?

Data mining across key dimensions would not only assist companies in developing a risk model for different lines of business but also in underwriting in many ways and definitely will aid in answering the question of detariffing by providing intelligent inputs. Multi-dimensional analysis of data is equally important for an enterprise. A representative sample of business intelligence reports based on different dimensions for analysis purposes appears in the box item(page 16).

Structuring the data across the business processes/ functions will project a unified picture for a profitable business operation. Data warehousing and mining technologies will provide an impetus to the ongoing efforts of the industry to move towards a detariffed insurance market. It would support the company in making informed decisions whilst providing accurate and timely information in a simple format to authorised people. Data warehousing/ data mining will contribute to the overall objective of the companies to increase revenues, reduce costs, locate and target higher value, profitable customers, restructure product offerings and minimise losses due to error or fraud. It impacts practically the entire spectrum of the insurance business. The potential returns could be significant for the market as a whole.

The author is Functional Consultant, Finance and Banking vertical, Wipro InfoTech. The observations made in this article are in his personal capacity and do not in any manner reflect the company's understanding of the subject.

TPAs and the Regulator

G.P. Sureka

The need for the concept of managed healthcare was first felt in the US and the system of managed healthcare financing and delivery was introduced in 1973. The first question in the mind of an amateur will be: what was the need for such a system?

With development and advancement in technology including in healthcare, the cost of medical care was rising constantly and reached such heights that it became practically impossible to extend healthcare assistance to all the employees of a corporate and the government, not to speak of individuals. Just to keep medical costs under control and at an affordable level managed healthcare was introduced in the US.

To organise managed healthcare systems, third party administrators (TPAs) were brought in and they became popular as health maintenance organisations (HMOs). With tight control over the patients' network service providers HMOs became most successful in their primary aim and made the healthcare affordable for almost 80 per cent of the American population.

After opening up of the economy in India, the technology in the health sector has advanced. Many corporate hospitals mushroomed in the metros with world-class facilities and with latest equipment imported from across the world. Obviously with all these facilities and with high capital investment, the cost of healthcare increased in geometrical progression making it unaffordable for the common individual and the corporates as well.

On the other hand, all who could afford it, even if it meant stretching financial muscles, always tried to get the best facility available. Such efforts even put some people on the verge of poverty but the need for the medical treatment and the attitude to want the best facility compels people to opt for such treatment.

When the Government of India passed the IRDA Act in 1999, it became the prime aim of the authority to make life easy for the policyholders including those in health insurance.

Keeping in mind the rising cost of healthcare the concept of TPAs was introduced in India also by the regulator and some 22 companies have been issued TPA licenses so far. Though the TPA concept introduced in India is on the lines of the system launched in America, it has basic differences on the following lines:

1. The HMO in the US is allowed to underwrite the risk on its own books whereas TPAs in India are not allowed to do so.
2. The HMO in the US is an independent organisation whereas TPAs in India are attached to one or more insurance companies and they can get business only through insurance companies.
3. HMO services can be offered by any

hospital in the US whereas in India TPA services cannot be offered by a hospital.

4. A HMO can have its own chain of hospitals whereas a TPA is barred from entering into any other business activities.
5. A HMO has the authority to admit its member at a hospital of its choice as per the risk covered to curtail the cost of treatment whereas a TPA does not have such authority. The selection of the hospital is the privilege of the patient and the TPA can only monitor the hospitalisation process and pay the claim on time to the hospital by liaising with the insurance companies – which gives the patient a cashless facility.
6. The policyholder can still choose a hospital which is not on the network of the TPA and opt for the reimbursement procedure.
7. TPAs are not allowed to do marketing and also not allowed to advertise without the permission of the insurance companies.

Apart from the above deviations from the original system of managed care, TPAs do not have the authority to offer a choice of an improved product to the policyholder. The TPA is forced to provide service to the policyholder for an obsolete product – the Mediclaim policy introduced at least almost two decades ago. Since the introduction of the product none of the insurance companies have ever thought of bringing out new products but are just bottling the same old wine in some newly designed bottles making it very hard to digest it as a new product. The TPA has to offer the services on the basis of the directions it receives from the insurer and does not have any say of its own.

It is good that the Government of India has put the IRDA in place to look after the interests of all the insurers and insureds, but just passing legislations and framing the rules does not help.

In India there are more than 2000 Acts passed by Parliament and Gazetted but many are hardly enforced. Without proper enforcing agencies the Acts passed are just pieces of waste paper. For enforcing an Act very hard decisions have to be taken which are not necessarily pleasant ones. We always read in the newspapers about unruly mobs in the country, which at times become un-controllable, but have we ever thought who is responsible for this? I remember that same unruly crowd also settled in Singapore but they were made the most civilised people today all because the authorities there made such efforts at enforcement.

In India we have the habit of ignoring the law. We always feel that even if we do not follow the rules, the worst that we will have to face is a small fine or some warning, or we can even pay a little bribe and feel relieved from the sins we have done. Or ultimately some amnesty scheme will be introduced and people will be free from all their sins.

The TPA is forced to provide service to the policyholder for an obsolete product – the Mediclaim policy introduced at least almost two decades ago.

My view is that the regulator has to enforce the regulation with tough actions. In the January 2003 issue of the IRDA Journal I read about the reasoning given by the insurance companies about the ignorance of a regulation (on payment of interest on delayed claims payments) notified by the authority, which after the lapse of 10 months insurance companies were not following. The reason this kind of thing happens is very simple. We have the tendency to ignore the law as far, as it is the company that pays the penalty, because it does not cost the officer concerned!

I suggest the following to enforce the policyholders' interest which may sound unpleasant:

1 Underwriters must be forced to settle or reject the claim strictly within 30 days giving full reason if rejected.
2 If this is ignored, the interest paid over and above the claim amount should be deducted from the salary of the officer responsible for the delay, whoever he may be. There should be no room for pity in the enforcement of this.
3 If it is found that the claim was rejected on flimsy grounds just to gain time, the policyholder shall be paid the interest for the delay.
4 Ignorance of the law is no excuse, the entire officers and staff members of the insurers are supposed to know the regulations published and they should not wait for someone to inform them. The regulator has made it easy for them to update their knowledge just by reading its website.

Empanelment of TPAs

I was surprised to see the way the empanelment of TPAs was handled and the Authority remained silent over the issue. When the Authority issued TPA licenses after full scrutiny of the technical and financial capabilities of the companies concerned, how can insurance companies and the General Insurance Public Sector Association (GIPSA) re-examine the technical capability of the TPA?

It seems to me that GIPSA stepped in the shoes of IRDA to re-examine the technical capabilities of the licensed TPAs, which was grossly an act of overruling the directions/ decision of the authority. The whole exercise of empanelment has monopolised the TPA business under the umbrella cover of the

Government/ Authority. The Authority has every right to scrap the whole proceedings and to direct the underwriters to empanel all the licensed TPAs. Empanelment does not guarantee business. The fittest will survive. One who gives satisfactory service will get the business.

Premiums and the TPAs

When TPA services were introduced in the health sector it was presumed that insurance companies would save a lot of overhead costs on the post-underwriting services if these jobs are transferred to TPAs and therefore they shall pay the service charges to the TPA out of the premium.

As per an estimate the insurance companies used to spend about 18 to 30 per cent of the premium as overhead expenses for providing service to the policyholders in the health sector. Moreover, the premiums on the Mediclaim policy have gone up by about 30 per cent since January this year.

To my utter surprise GIPSA loaded the premium on all Mediclaim policies by six per cent towards TPA service charges. To my mind this loading of service charges is a reward for their inefficiency. If we accept that the policyholder is made responsible to pay for the services he is availing, then why is the insurer imposing a TPA on the policyholder? If the policyholder is paying he should have the right to accept or refuse the services of a TPA, negotiate the charges if he opts for one, and should even have the right to select a TPA out of those licensed by the IRDA.

Watching over the TPAs

The working of the TPAs should be strictly watched. There are a lot of whispers in the market about the poor services rendered by some of the TPAs empanelled by the insurers. The regulator should keep a watch through audits, inspections, reporting etc. over the services rendered by the TPA. The insurer hardly has any interest in their services. So far when the insurer itself could not provide any services to the policyholders what interest would they have in the indirect services provided by the TPA. Even now the insurer is not willing to settle the claim on time. It takes a minimum of one week after the fully processed claim file, with doctor's report, is submitted. Sometimes the insurer makes excuses of non-availability of funds, sometimes the staff member concerned is absent, and sometimes it might be that there is other more important work for the working staff either personal or that of the company.

Sometimes they refuse to recognize the TPA. I have seen cases where the claim of an Ayurvedic hospital was paid by one PSU insurance company in the case of its own staff, but when a claim by another policyholder was submitted for treatment in the same hospital it was refused on the pretext of not having an operation theatre. It is astonishing why the same theory was not applied to its staff member.

If the policyholder is made to pay for the services he is availing, then why is the insurer imposing a TPA on the policyholder? The policyholder should have the right to accept or refuse the services of a TPA.

There are whispers everywhere that it is the staff members of the PSU insurance companies who highly misused the Mediclaim policy in making false claims and compromised the whole policy system.

The Government of India has been trying hard to popularise Ayurvedic and Unani systems of Indian medicine but insurance companies have been deliberately discouraging it. An Ayurvedic hospital cannot get itself registered with Medical Council of India without an operation theatre since it is not part of that system.

Relaxing the rules for TPAs

To make a beginning, whatever rules are framed for TPAs are good enough, but sooner or later the Authority must keep in mind that finally the HMO system is the only answer to the rising cost of healthcare and it should slowly take steps that allow TPAs to convert themselves into HMOs in their original sense with the powers to underwrite risk.

When converted into HMOs they will be able to control the cost of healthcare and will be able to act as TPAs and also as Preferred Provider Organisations (PPOs). If the PPO system starts, new and innovative products in health insurance will be introduced as per the requirement of the people and also as per the paying capacity of a person. They should be encouraged to take more interest in community health schemes for which the authority must prescribe minimum service charges.

The community health schemes can be offered at a very low premium but a 5.5 per cent service charge on that premium may not cover even the cost of photo ID cards. This is the principal reason no TPA is coming forward to offer services in case of community health schemes. No scheme can function until and unless it is designed on totally economically viable terms.

Charity is wholesome but it can never work in business and this must be understood. It is therefore the responsibility of the Authority to devise a formula where the TPAs are encouraged to take part in such schemes and that is only possible if the minimum service charges are fixed.

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How Much is Too Much?

K. Nitya Kalyani

What's a fair price for a service? That's a question that has no clear answer except perhaps that the price would reflect what the service is worth to the customer.

Going by that, the general insurance industry in India should be willing to pay out quite a bit to get business today.

Private insurers, though they have captured almost 10 per cent of the market, and quite quickly, are hungry for business as they have the capacity to spare. Public sector insurers need more business, but high quality business, as they are struggling with low profitability. What they need is an immediate increase of their volumes for any recovery. That and some pretty serious belt-tightening as far as their unproductive overheads go.

The public sector non-life insurers don't see it that way. Their worry is that 'with our present bottomline, we cannot afford higher marketing costs.' But ironically, the fact of the matter is that, with their present bottomlines they cannot afford not to spend more on marketing. And not just more money, but more time, attention and efforts and better strategy. They just have to drive hard the acquisition of more business because the only way to get out of the trap they are in is to write more business.

The current narrow focus on intermediation costs alone – which is happening under the pressure of poor investment returns on top of poor underwriting performance – will be counterproductive too. Literally every Rupee saved today under this head is an opportunity cost. They cannot sit back when the competition is breathing down their necks.

One focus of this discussion about intermediation costs is obviously their aversion to brokers. General insurance brokers have not been present in the Indian market except for reinsurance, and since all large business was deemed to be procured by team effort a five per cent special discount was given on the premium to the insured instead and no intermediation charges were payable.

But 'consultants' did offer their expertise to the insureds, and were paid by them for their value addition in negotiating terms and rates with the insurers and even tying up reinsurance arrangements. With brokers being licenced in the direct market recently, the genuine problem that the public sector now faces is that insureds would want to deal with brokers as brokers now and that bill would have to now be paid by the insurer instead with no way of passing it on to the customer because of the tariff!

Which means the cost of procuring business would go up almost automatically from the five per cent discount to 10 per cent or more depending on the type of business and the brokerage it attracted. Under this set of circumstances their anxieties are justified, but then it is the tariff that is the anachronism in this scene. Without the tariff, the brokerage would merely be factored into the premium quotation.

> Ignoring a distribution channel is something a mature market or one heading for maturity just does not do. The public sector insurers just cannot wish away intermediaries in an untapped market.

This loss to the public sector non-life companies was anyway stemmed by the IRDA on March 20 when it disallowed brokers from soliciting business from government and public sector insureds who contribute a bulk of the premiums.

This is a temporary reprieve at best for public sector general insurers. Not using brokers is going to be counterproductive in the long run for them and to the government and public sector insureds who have been denied the use of this intermediary.

Ignoring a distribution channel is something a mature market, or one heading for maturity, just does not do. The public sector insurers just cannot wish away intermediaries in an untapped market, more so when their own marketing apparatus was never sharp or productive and does not look like it will turn efficient overnight. The private sector is going to use this opportunity to woo and use brokers aggressively, and it will be another opportunity lost to the public sector insurers in a world where cultivating relationships means everything in business.

The insureds shut off from brokers lose out equally badly. The general insurance broker brings prime value to the table when he negotiates favourable terms for his client, the insured, and just one of them is the premium. Insureds in this category will not be able to avail themselves of the expertise on offer as brokers something for which they have been, through these very decades, retaining the same consultants and paying them.

Retaining business is costly too. Though not as costly as losing customers. This is what the life insurance industry is facing today. Lapsation rates are high and, as a parallel, attrition rates are high among agents in this almost exclusively agency driven business.

In the life business there is a clear and strong of strong intermediation – the Life Insurance Corporation (LIC) does not accept any direct life business. The issue that this sector is concerned now with is the manner of compensating them with the objectives of retaining both the agent and the business over the long terms to the best advantage of the insurer, the insured and the agent.

And one thing that cuts across both sectors is rebating. LIC agents have been rebating for a long time though this is an offence under the Insurance Act, and their private sector counterparts seem to be following that famous Indian 'market practice.'

Equally unacceptable in strict legal terms is the five per cent special discount on the tariff for large insureds where agency commission is not payable. The industry is divided down the middle with private sector players wanting it out and the public sector insurers wanting status quo and then some. But it remains that the discount is technically a rebate and should find its way out. That it survives today is because it is, yes, 'market practice.'

Rightsizing the Price

– Marketing Compensation in Life Insurance

Apparao Machiraju

According to researchers, the industry practice that perhaps contributed most to marketing problems in the life insurance industry in India is the traditional compensation structure for distribution system, which is a high first year commission followed by lower renewal commissions.

This structure has been there for decades. The rationale for it follows from the belief that life insurance is not bought by the customers but has to be sold, and the concomitant belief that high initial commission is essential if agents are to have sufficient motivation to sell.

Companies are concerned with structuring compensation in a way which will allow them to develop competitive products and encourage long term persistency. The heaped commission structure puts strain on early policy values and rewards new business significantly more than retained business.

The belief that consumers will not purchase life insurance on their own or, as a variation of this theme, through a commissioned agent, is today open to debate. It is true that the majority of consumers need prodding by someone to purchase life insurance. But that someone need not be a commissioned agent, and if the person is an agent, he or she need not necessarily be compensated through a heaped first year commission structure. Some thought leaders suggest that the very compensation system that the insurers use causes the agent's interests to differ from those of the insurer and the policyholder.

The issue of the traditional commission structure is not so much whether alternative approaches would work well but rather whether the existing structure is compatible with the life insurance industry's long-term good. The life insurance business is best served through an agent compensation system that is designed as profitably as practicable with the long-term good of both the insurer and the policyholder in mind.

If the company places high value on quality advice and service, and on maintaining long-term customer relations, its compensation system should reflect as faithfully as feasible the degree of importance the company attaches to these elements. If the system establishes only minimal rewards for excellence in these areas as compared to new sales, the company management cannot profess surprise when employees and agents respond in ways inconsistent with stated corporate goals.

In distribution, the role of sales compensation is the third leg of the proverbial three-legged stool for successful marketing results. The other two are products and service. Companies viewing the compensation system from the broader perspective of distribution strategy need to come to terms with the relative importance of the three legs of the stool in the overall scheme of things. As expected, all the three legs must support the marketing effort.

Some thought leaders suggest that the very compensation system that the insurers use causes the agent's interests to differ from those of the insurer and the policyholder.

Historically, companies all over the world have been focusing on aggressive sales compensation payouts as the best route to marketing success. There is evidence that this strategy is failing as the industry is under pressure to move further to face market place realities.

Demographic trends leading to consumers worrying about post-retirement capital requirements, financial consequences to dependent families in the event of untimely death, additional capital fund requirements to provide for contingencies including sickness disability and hospitalisation and sustaining overall financial health are the concerns.

Allocation of limited resources to meet these needs lead to need-based counseling/ selling and product mixes which affect commission incomes.

The compensation implications of a shift of product mix from primarily long-term life insurance, pure term products and accumulation products can be expected to place additional pressure on companies to review their sales compensation approach relative to current and future market place demands.

Relatively new agents are under great pressure to produce new sales. Not surprisingly, under such a system they may become more aggressive in their sales tactics and, being inexperienced, may provide incomplete or misleading information in their efforts to meet sales targets. Failure to establish and enforce clear market guidelines as well as inadequate agent training and supervision have played important roles as well.

Consumerism too is expected to play an increasing role in sales compensation practices. Today, there is a growing suspicion that the interests of the company, its distributors, and its customers are mismatched with the traditional high sales compensation structure. Matching products to

customer needs, as determined through an organised evaluation of those needs is a trend in the market place that is expected to affect the sales compensation structures in the not-too-distant future.

Finally, as the competition for acquiring customer base in the more broadly defined financial services intensifies, insurance companies will need to pay more attention to their existing consumer bases also. The traditional sales compensation system, i.e. the heaped first-year commissions that focus almost exclusively on the acquisition of new business without paying attention to the existing policyholder base, will come increasingly under pressure. Holding on to existing customers can be expected to play as much of a role in the future as acquiring customers does to current distribution role in customer management with a corresponding impact on sales compensation systems. Distribution attuned to active customer care will emerge.

The front-end (first-year) commission structure emphasis no doubt instills a sense of urgency and focus in the sales force. In terms of product pricing, front-end sales systems also can deliver reasonable distribution cost levels if premium persistency expectations are achieved through quality business.

On the downside, high-sales commission approaches are criticised for encouraging unethical sales behaviour. Products sold that do not match customer-need, policy replacement to the customers' disadvantage and the recurrence of the unethical intermediary who profits greatly at the expense of both the customer and the company are the largest detriments associated with the high-sales commission approach. Another growing concern for long-term life insurance products involve the company's ability to market early cash value accumulation products.

Another aspect of the high front-end commission system in today's market place is their tendency to encourage ambiguity as it relates to providing service to existing customers. As briefly discussed above, in the expanding competitive world of financial services a system that does not address the need of existing customers is an increasing liability.

Levelised Compensation

Canada is the clear industry leader in implementing levelised life insurance commissions. The Canadian industry has proven that companies can move significantly away from the traditional high front-end compensation approach and be successful. Great West life and Mutual life Canada have proved that insurance distribution can be compensated on a significantly different model than the traditional high-sales compensation approach.

Holding on to existing customers can be expected to play as much of a role in the future as acquiring customers does to current distribution role in customer management with a corresponding impact on sales compensation systems.

A company considering levelised approach seeks to better align its interests and the interests of its distributors and customers. Compared with traditional compensation, distribution profits from continuing relationship with or persistency of the customer rather than primarily from sales. This is an increasingly important consideration in the light of growing competition in the financial services industry and the heightened interest in compliance.

The expectation of levelised systems is increased producer (for example, agent) retention. The theory is that producer retention will improve from two perspectives. First is the stability of cash flow. Producers who have developed a customer-base can rely on the income from that base without significant fluctuations. This should lead to higher retention in the sales force.

The concern to the company is sales growth in total. If the levelised approach can develop higher producer retention, it stands to reason that the company can also develop a growing sales force that will deliver overall increased sales to the company.

Productivity requirements also play a major role in managing the levelised commission approach. Companies involved with level commissions invariably create contract standards that maintain the need for sales results; regardless of the customer base for an individual agent. The concept of minimum productivity requirements is enhanced under the levelised commission scenario, since the agent has much more to lose by not maintaining minimum expectations than if he was working with traditional high first commissions.

Another issue is the perceived misalignment of compensation relative to the efforts in increasing sales versus maintaining ongoing customer relationships. This is a valid agreement; however, in the broader financial services perspective, there is an increasing sentiment that focusing on total premium and assets is a more important measure of success than focusing only on the sales side of the equation.

Transitioning to levelised commissions is a major commitment: This occurs in two forms.

1. Providing transition to existing producers through recommissioning on additional sales subsidy, and

2. Developing an information system that will accommodate the needs of a levelised structure which requires a significant resource commitment.

Companies abroad implementing levelised systems are pleased with their results. The approach is consistent with industry trends, in terms of the alignment of the interest of agents, customers, and companies.

Salary Plans

Salary-based compensation systems are also in vogue among some companies. This, in large part, is due to the entrance of banks into the marketing of insurance. Bank distribution in many cases is salary-based.

Successful salary-based sales compensation systems rest on two underlying distribution dynamics. The first is the need for solid activity management procedures. Companies employing a salary approach do so by clearly directing the activity of the sales force. There is an expectation that through activity control, the organisation will manage sales productivity levels significantly and better than industry norms. In doing so, the company will also benefit from an economy of scale associated with the fixed cost salary system, of which it cannot avail itself under a pure commission approach.

The second fundamental requirement for the success of a salary based system is the ability of the company to provide prospects for its sales force. One of the reasons for bank distributors to choose salary systems is that they can provide sufficient insurance prospects through the existing bank customer-base. Without a successful prospect identification methodology, salary systems run a significant risk of increasing distribution costs over similar commission-based systems.

Agent Financing Plans

The basic method of compensating sales force has continued to be the commission contract with varying proportions of the selling commission deferred. The deferred nature of the agent's compensation has always made it difficult for sales people to earn a living in the formative years. For this reason, various methods of 'financing' new agents have developed. Almost all financial plans assume the gradual adjustment of the agents to a commission contract.

The principle underlying the earliest finance plans, and many current plans as well, is simple. Funds are advanced to the agent against the value of the future commissions on business he has sold, discounted for interest and persistency. Financing plans are designed to include a training allowance or subsidy in the formative stage which will not be treated as part of financing linked to indebtedness.

Companies not restricted to narrow types of agent compensation methods incorporate both salary and incentive compensation. This approach will help companies to recruit people previously disinterested because of their greater need or concern for stability.

Successful implementation of financing plans depend upon their design as well careful monitoring by those in sales management. Evolution of the career agency system in the US is due the financing approach by many leading insurance companies. It can be said that a career agent's building approach is known as the breeding ground for successful agents developing as independent agents, brokers, agency managers and senior executives.

Emerging trends

In the emerging competitive environment productive agents will become more valuable. The agents who do survive are more likely to be the same ones who develop into experienced professional agents, who move to serve the upscale markets.

Life insurance is not typically a demand product. Among lower and middle-income households the proportion of the uninsured and underinsured continues to grow. Hence, one hears much these days about the so-called 'underserved markets'. Companies not restricted to narrow types of agent compensation methods incorporate both salary and incentive compensation. This approach will help companies to recruit people previously disinterested because of their greater need or concern for stability.

In the current context in India, the new type of intermediaries – corporate agents, brokers, and banks are yet to position themselves in the market place. The transition period can be termed as 'period of discontinuity'. Altogether a new type of intermediary system has to evolve. Designing appropriate compensation plans will continue to be the key issue in being able to attract and retain sales personnel in all the situational contexts – whether be it broker firms, banks or companies dealing directly with agency force.

The author has had inter-disciplinary background in life insurance for four decades in Management, Marketing, Research, Training and Teaching. He has taken to full-time teaching and has been the Founder/ Director of College of Insurance and Financial Planning (CIFP) established in 1991. Currently he is the Director of International Institute for Insurance and Finance (www.iiifindia.com) located on the Osmania University Campus, Hyderabd.

Management Over Marketing – Costs in Non-Life Insurance

G.V. Rao

This article seeks to analyse the present overall management costs of insurers in general, and examine if intermediary remuneration is one of the factors that is proving to be a roadblock for stimulating insurance awareness for developing new markets.

The cost of doing business is a part of the pricing structure offered by insurers to the insuring public. Do insurers feel the need to cut down their business costs or add new features to the available covers to make their value proposition interesting enough to potential customers? What are the insurers now actively doing to reduce their management costs, to be able to increase their distribution compensations, for making it worthwhile for top-class agents to be attracted to work in the insurance profession?

The present behavior of insurers indicates that their marketing strategy is still based on a mindset of responding more to the demands made on them by the buyers than in aggressively creating a market of potential buyers, who need insurance but do not know how to go about it.

Insurance awareness and low penetration

One of the reasons proffered for the low penetration of insurance awareness is the high initial cost of educating a customer of the need for insurance protection and persuading him to buy a cover with money from his pocket. The insurers, in the post-nationalisation period, therefore, focused on building business through easily available sources such as banks and financial institutions and on a growing Motor portfolio.

Creation of insurance awareness in the potential customer base was not felt as a pressing need of the moment, till now.

What are the factors that have brought about a change in the insurers' current plans?

Competition and rising customer incomes

With competition now ushered in through the entry of private players and with a rapidly growing middle-class with disposable incomes looking for protection of its assets and personal interests, creation of new markets from the hitherto untapped sources, particularly from personal line insurances, has come to the fore.

Insurers are now searching for marketing methodologies to tap this source, and are finding that their present distribution channels are not geared to the task. Agents, an unwanted class till now, are back in the reckoning after the IRDA regulations have brought in a semblance of professionalism to their recruitment. Agency remuneration and brokerage are currently hot topics; and so is their role, in view of the lack of a marketing infrastructure on the part of private sector players.

Despite mostly selling customer demanded covers the cost of doing business has remained high, as insurance business was run more as an administrative mechanism and not really as a marketing organisation.

Competition, a qualified agency force and a cash-rich middle-class have given a new fillip to personal lines insurance. But the sheer variety of covers, inadequate agency remuneration and a casual attitude towards nurturing agents are slowing down the marketing initiatives. How should this logjam be broken?

Infrastructure expansion

The nationalised insurance sector initially took on the task of rapid expansion of infrastructure by setting up offices all over the country to make insurance covers available to those interested in buying insurance on their own. Since a tariff regime, wherein the rates and terms are fixed, has been in place, competition among the public sector players was restricted to building relationships with the customers that mostly bought tariff covers. Fire, Marine, Motor and Engineering businesses come under this category.

Despite mostly selling such customer demanded covers the cost of doing business has remained high, as insurance business was run more as an administrative mechanism and not really as a marketing organisation. Unlike in life insurance, where agents played an important role in developing business, in non-life sector salaried employees are entrusted with selling responsibility.

Lender & employee driven market

The insurance market, except in the case of Motor, has been mostly lender-driven. Only those covers that lenders have insisted upon became the target of sales. Even tariff covers that are not lender-driven did not take off in any significant way. Business interruption insurance is an example.

Motor business grew in big volume and was the quickest to develop. In either case, there was not much selling to be done on the need for covers or their benefits.

The agency intermediary structure that was heavily abused in the pre-nationalisation period is now relegated to selling covers to companies with small capital base and for individuals. Almost the entire selling operations are left to the Development Officers who have acted more like contract workers of an outsourced network.

The industry, subjected as it is to increasing employees' pressures seeking benefits for themselves than serving the interests of the customer, has lost the initiative to expand the market by creating insurance awareness among the vast public for need-based covers. At the same time, to keep the employee motivational levels high, promotions are given on the basis of premium volumes and not because a promotional position is justified.

Improvements in technology and in communications that ought to have cut costs did not make a difference.

The industry continues to be more employee-oriented than customer focused. A customer is regarded more as a part of a business transaction and not a stakeholder for the survival of the industry. The following performance figures justify this statement.

Operating losses and costs

The public sector in 2001-02 wrote an earned premium of Rs. 8,470 crores (Rs. 7,800 crores for the previous year) at a cost of 31 per cent (28 per cent). It operated on an incurred loss ratio of 93 per cent (90 per cent) taking the combined ratio to 124 per cent (118 per cent) resulting in underwriting loss of Rs. 2,100 crores (Rs. 1,400 crores).

With commission costs for agents at about 3 per cent and a tariff regime in place restricting competition to customer relationships, why is the cost of doing business for a customer with an insurer so high at 31 per cent on earned premium? In 2001-02 the management costs incurred was Rs. 2,650 crores (Rs. 2,200 crores). The industry's earned premium grew by Rs. 670 crores in 2001-02 whereas the costs went up by a whopping Rs. 450 crores!

No stakeholder has shown any interest in this alarming situation. The cost issue continues to remain neglected. Yet, any idea of increased remuneration to intermediaries to create new markets is met with stiff opposition by the industry on the plea that it is incurring heavy operating losses and is just not in a position to take on any more financial burden! There is no answer why the management costs, excluding the agency costs, should remain so high in contrast to any other insurance market in the world. Not only is the service given to the customer not entirely satisfactory but is proving to be very expensive too. It is obvious that the industry has not shown enough concern to bring down its cost structure; but is now upset that the intermediaries too are demanding a share of the pie!

It is obvious that the industry has not shown enough concern to bring down its cost structure; but is now upset that the intermediaries too are demanding a share of the pie!

If insurers are really concerned about their losses, they should not only cut the flab by offering VRS to their staff but look at the present high cost of supervisory structures at the regional offices (ROs) and head offices (HOs) that make little contribution to the divisional offices (DOs) and branch offices (BOs), the business producing centres. There is no analysis or evaluation put out on the costs incurred on running an RO or HO; and whether the costs are justified in terms of value creation or contribution.

One obvious way of reducing present operating losses is to look at and prune management costs wherever possible. Perhaps the industry feels that this is an area in which it is helpless and hence is not effective in controlling costs. Non-salary related costs need greater scrutiny and managements should ensure that only absolutely necessary costs are incurred. Controlling expenditure through a budgetary mechanism based on the previous year's expenditure incurred is an anachronism.

A classic situation has arisen wherein the industry is not able either to create or tap new markets to grow in volumes due to lack of a proper and adequately remunerated distribution network but goes on spending money on its employees to keep them happy. This dichotomy of approach to its cost structure is difficult to explain. Nor has anyone questioned the insurers so far on it. The industry perhaps feels that it is not accountable to any stakeholder for its actions in producing unprecedented losses in addition to running the business at a high cost structure. Is it just the market and tariffs, and not the managements that are responsible for the deteriorating situation on both fronts?

How should insurers cut costs?

With the likely dismantling of tariffs, managements should focus primarily on reducing management costs as a competitive advantage in working out internal rating structures. The job content of an individual employee should be measured in terms of output and contribution and the relative costs that he or she adds. Travel and entertainment for purposes other than customer-related issues should be closely monitored. Promotions should be need-based, and promotional vacancies should not be created on premium volumes. It is work and its

quality that should justify positions. Cost consciousness should be a doctrine and a creed in the entire organisation. Non-salary expenditure should be based on zero-budgeting principles and not on incremental pushes. E-commerce should be the corporate language for speedier communication within to reduce unnecessary job creation and needless costs. Reengineering processes of policy issuance, claim settlements, accounting issues and reporting should be reviewed to cut down present wasteful practices.

Organisation structures should be re-examined and redrawn. The head office should become lean and mean. It should be an information receiving centre for planning strategies and reviewing results. No operational responsibilities should be vested with it in claims, underwriting and administration except in finance, reinsurance and accounts. Local head offices should be set up at metro centres under general managers for better co-ordination and sharper customer focus. ROs, DOs and BOs should be strengthened with posting of qualified and experienced staff to ensure customer services dramatically improve.

Marketing should be an exclusive important function under designated senior officials at ROs and DOs, without an overload of administrative responsibilities attached to them, to support the developmental efforts of regional managers (RMs) and divisional managers (DMs) for creation of new markets and to widen the customer base. Training of agents and staff, adoption of new marketing strategies and customer education and contact campaigns should receive top attention to improve business volumes.

Changing the management mindset from command-and-control mentality to a collaborate and connect mentality is a transformation that is very necessary. This change should be the preoccupation of the top leadership. Cost consciousness and return on money spent should be an embedded thought in every employee. Managements should do everything it can to get this message across to all. But is anyone listening or concerned?

Agency remuneration

The IRDA annual report claims that over 5,00,000 agents have been recruited under the revised agency regulations in the life and non-life sectors; many of them for rural business too. There is no analysis of how these agents have been nurtured and how many can be classified as successful agents. Why have the other agents failed? What have the insurers done to build them up? What covers have been preponderantly sold by them? Are insurers satisfied with this new distribution channel? What more needs to be done? Is top management engaged in reviewing the status? There are no answers available as the importance of agency network in non-life business has never been recognised.

Agency remuneration should be raised depending on the profit generation probability of the cover. The industry should also bring about a campaign-like approach to sale of such covers.

Individual optional covers need more detailed knowledge of the scope of cover, improved communication skills and a keenly felt empathetic attitude towards the customer. The industry has done little in training its sales and agency staff in acquiring them or pushing need-based covers as a deliberate strategy.

It is generally accepted that personal lines business, with the exception of Health and Motor businesses, is profitable. Householders' insurance and several other individual insurances need hard selling. Agency remuneration should be raised depending on the profit generation probability of the cover. The industry should also bring about a campaign-like approach to sale of such covers.

Brokers' remuneration

There is no need to revise brokers' remuneration for the present as more commercial entities than professionals have come in to this network to cash in on the easy entry norms. For the present their value proposition is to offer kickbacks to the insured and nothing else. Till detariffing takes place in rates and terms, their remuneration position can be frozen. This time, interval should be adequate for insurers to set their annual cost budgets in order and to bring down costs for customers, so very essential in a non-tariff market. The insurers should become obsessed with their customers rather than with their employees as at present.

Conclusion

Customers cannot afford to continue to keep service providers in the present state of luxury. Either cut costs or expand business volumes to justify costs incurred. As insurers in the public sector, they have an obligation both to customers and investors to ensure products made available are cost-effective. Only insurers know where their costs can be cut. But they need to be more serious about this objective and examine if staff productivity levels can be improved.

Now that VRS is in full swing there cannot be a better opportunity to examine deployment of remaining staff, restructuring operations and zeroing in on marketing opportunities through agency network, if necessary through enhanced remuneration policies in selected covers. But the industry needs to break out of the shackles of status-quoism, so very evident to all except perhaps to those chained.

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प्रकाशक का संदेश

जर्नल का एक और अंक आपके सामने है। इस अंक में मध्यस्थ कारोबारियो तथा उनकी लागत का वर्णन है।

भारतीय बीमा उद्योग में अब तक केवल एक ही मध्यस्थ को देखा गया था। वह था बीमा अभिकर्त्ता जो निरंतर कई बार अपने भावियों को बीमा कवर की आवश्यकता के लिये एक राय करता था। हमने न केवल उसको योग्यता प्राप्त कारोबारी बना कर उसका कारोबारी प्रोफाइल बदल दिया वरन् हमने कई अन्य मध्यस्थों को भी साथ लिया है।

विक्रय तथा वितरण के क्षेत्रों में नये कारण जोडे गये हैं इसलिये इनको दिये जाने वाले प्रतिफल पर पुर्नमूल्यांकन करने की जरूरत है। जिससे बदलते हुये समय में भी यह न्याय संगत बने रह सके। आज जैसी स्थितियाँ है उनके अनुसार जीवन बीमा का अभिकर्ता पहले वर्ष के प्रीमियम में से अनुपातिक रूप से काफी ज्यादा कमीशन प्राप्त करता है तथा दूसरे वर्ष तथा उसके बाद कमीशन धीरे धीरे कम हो जाता है। इसके कारण कई बार बीमा की सत् ता को ठेस पहुचँती हैं क्योंकि अभिकर्ता पहले से किये गये बीमा की अपेक्षा नये बीमा की तलाश में रहता है तथा अपने पहले के ग्राहकों को कोई सेवा नही देता - प्राधिकरण ने ऐसा अनुभव किया है कि इसका कोई विकल्प होना चाहिये जिससे कमीशन को पालिसी अवधि के दौरान फैलाया जा सके इसके लिये एक समिति का गठन इसकी जाच करने के लिये किया गया है। समिति आजकल अपना कार्य कर रही है तथा मई प्रथम सप्ताह में अपनी रिपोर्ट प्रस्तुत कर देगी।

अगला अंक जिसके बारे में पाठकों से चर्चा करना चाहता हूँ वह है विनियामक तथा साधारण जनता के बीच जर्नल अच्छा संवाद का माध्यम है, इसकी प्रशंसा अंतर्राष्ट्रीय स्तर पर हुई है। अच्छे प्रशासन के लिये यह आवश्यक है तथा यह गुण प्रभावशाली संवाद की कला है जो विनियामक तथा विनियमित के बीच एक जर्नल या मैगजीन के रूप में आपके सामने है।

मार्च 2003 की समाप्ति पर व्यापार की अंतरिम सांख्यिकी इस जर्नल में अन्य स्थान पर प्रकाशित की जा रही है। प्राधिकरण उपलब्ध आकडों से यह उम्मीद करता है कि बाजार विकास के लिये तैयार है तथा साधारण बीमा में प्रगति अपेक्षाओं के आधार पर हो रही है। 13 कंपनियों द्वारा इकठ्ठा किया गया सकल प्रीमियम साधारण बीमा व्यवसाय में 14279 करोड है जिसमें पिछले वर्ष की अपेक्षा 25 प्रतिशत की वृद्धि परिलक्षित होती है।

साधारण बीमा ने क्षेत्र विशेष में अच्छा काम किया है तथा उसको शाबासी देने की जरूरत है। निजी क्षेत्र की कंपनियों के पास साधारण बीमा के कुल प्रीमियम का 10 प्रतिशत भाग उपलब्ध है।

जीवन बीमा व्यवसाय के आकँडे भी आ गये है तथा यह देखा गया है कि भारतीय जीवन बीमा निगम के प्रीमियम में तीव्रता से गिरावट आयी है। इसका कारण यह है कि निगम को 2001-02 में कुल बिक्री में कमी थी। पाठक यह जानते ही होंगे कि सरकार स्वयं इस प्रकार की पालिसीयों को पीछे रखना चाहती है जहाँ वार्षिक प्रीमियम बीमित मूल्य के 20 प्रतिशत से अधिक हो जिसका आधार कर हो। इसलिये एलआईसी के व्यापार का चरित्र पिछले वर्षों से काफी अलग था इसके बावजूद एलआईसी का कार्यनिष्पादन काफी अच्छा रहा। इस क्षेत्र में निजी कारोबारियों ने भी कुछ कर दिखाया तथा उनका व्यापार सकल व्यापार का 10 प्रतिशत तक पहुँच गया।

हैल्थ बीमा क्षेत्र में प्रगति न हो पाने के कारण चिंता व्यक्त की गयी। हैदराबाद स्थित स्वंय सेवी संस्था इंस्टीट्यूट आफ हैल्थ सिस्टम ने व्यवसाय के विकास में कुछ रूचि व्यक्त की और यह वादा किया गया कि वे एक प्रस्ताव के सामने आयेंगे, मैनें उनसे उनकी योजना पर अधिक शिक्षा देने को कहा है। इस पर अगले कुछ सप्ताहों में प्रगति होने की संभावना है।

जर्नल की प्रसिद्धि निरंतर बढ रही है। जिसको उन लोगों के अनुरोध से जाना जा सकता है जो अपने आप को डाक सूची में शामिल करवाना चाहते हैं। प्राधिकरण में हमें इसकी प्रगति की शनै शनै आशा थी। अभी तक हम 1250 प्रतिया प्रकाशित कर रहे हैं। आप सबके लगातार प्रोत्साहन मिलने के कारण यह संख्या निरंतर कम पड रही है जो जर्नल द्वारा अपनी जगह बना लेने का द्योतक है। इसलिये इस अंक से हम पत्रिका की प्रतियों की संख्या बढा कर 1500 कर रहे हैं। हमें उम्मीद है इस जर्नल के पाठकों की संख्या आने वाले महीनों में प्राधिकरण को निरंतर प्रोत्साहन देती रहेगी।

एन. रंगाचारी

जर्मनी में, नाजी सबसे पहले कम्युनिस्टों को पकडने आए,
मैं चुप रहा, मैं कम्युनिस्ट न था.
फिर वे यहूदियों को लेने आए,
मैं फिर भी चुप रहा, मैं यहूदी न था.
फिर वे यूनियन वालों के लिए आए
पर में चुप था मैं यूनियन वाला जो न था.
फिर वे कैथोलिक लोगों को पकड ले गए
मैं चुप रहा, क्योकिं में प्रोटेस्टेंट जो था.
जब वे मुझे पकडने आए, तब वहाँ कोई मौजूद न था.
किसी के लिए आवाज उठाने को..

- मार्टिन नीमोलियर

“ कुछ तो लोग कहेंगे ”

यदि अमेरिका की विधायी व्यवस्था को खुला छोड दिया जाए तो वह अमंरिका की उद्यमी भावना को समाप्त कर देगा तथा अमेरिका की अर्थव्यवस्था को बहा देगा. न्यायालय में किसी व्यक्ति, कंपनी, संस्था, या सरकार के विरूध याचिका दायर करना और ज्यादा से ज्यादा लोग न्यायालय में पहुँचे हैं. मेरे जैसे एक विदेशी के लिए अमेरिका की अर्थव्यवस्था की प्रणाली में जो बहाव है वह आश्चर्यजनक है.

लाड्स आफ लंदन के चैयरमैन लार्ड पीटर लौविन, शिकागो में भाषण देते हुए

यदि न्यायालय में लोगों पर आरोप साबित हो जाए तो अच्छा यही होगा लोगों को जेल जाना चाहिये.

श्री पीटर कोस्टेलो, फैडरल ट्रैजरार, आस्ट्रेलिया एचआईएच के ढह जाने पर रायल कमीशन की रिपोर्ट में परिर्वतन करते हुए.

यहाँ यह जोखिम है..... उच्च लेखापरिक्षक लोग अपने ग्राहकों के हितों के प्रति बहुत सहानुभूतिपूर्वक हो जाए, विशेष रूप से जबकि उनकी लम्बे समय की कैरियर भावनाएँ इस बात से जुडी हो की वे लेखा परिक्षा में कैसी भूमिका निभाते है.

न्यायमूर्ति नैविल ओवन, आस्ट्रेलिया एचआईएच के ढह जाने पर रायल कमीशन की रिपोर्ट में.

हम 10-15 प्रतिशत तक प्रीमियम की शुद्ध वृद्धि वर्ष 2002-03 में देखते हैं 2001-02 में हमने 49,000 करोड रूपये एकत्र किये लेकिन यह कठिन होगा कि हम पिछले वर्ष की तरह २० प्रतिशत वृद्धि दर बनाये रखें.

एलआईसी के अध्यक्ष एस. बी. माथुर

हमें वीआरएस की जरूरत नहीं है. हमें लोगों की जरूरत है जो हमारे बढते हुए व्यापार का प्रबन्ध संभाल सकें. हमें हमारे 10 करोड पालसी होल्डर को देखने वालों की जरूरत है. हर साल हम पहले के आधार में 10 करोड पालसी शामिल कर रहें हैं. जरूरत उन्हें त्वरित सेवा प्रदान करने की है. (ऐजेन्टो के लिए) (9.5 लाख)पर रूक कर क्वालिटी पर जोर देने की जरूरत है.

एलआईसी के अध्यक्ष एस. बी. माथुर कंपनी की कार्मिक नीति पर

हम पिछली सदी के सबसे बुरे बाजार में हैं. ब्याज दरें लगातार कम हो रही हैं. बीमा उद्योग का सारा ध्यान बीमा लेखन लाभ प्राप्त करने पर केन्द्रित है. हम उम्मीद करते है कि पी एंड सी सेक्टर में इस प्रकार की कठोरता जारी रहेगी.

जान कोम्बर, स्वीस री के मुख्यकार्यपालक अधिकारी

स्वैछिक सेवा निवृति योजना

स्वैछिक सेवा निवृति योजना जिसे वीआरएस के नाम से जाना जाता है वह चारों सार्वजनिक क्षेत्र की बीमा कंपनियों में अभी अभी लागू हुई है. जिसमें 11500 मजबूत विकास अधिकारियों के दल में से 12 प्रतिशत ने कंपनियां छोड कर जाने का निर्णय लिया है जबकि अन्य 20 प्रतिशत ने विपणन से प्रशासनिक क्षेत्र में प्रवेश करने का निर्णय लिया है.

पूर्वी क्षेत्र में अधिकत्तम विकास अधिकारियों ने विपण्न से प्रशासनिक क्षेत्र में जाने का निर्णय लिया

मूल रूप से स्वैछिक सेवा निवृति योजना के लिए आवेदन करने की अंतिम तिथि मार्च 3 थी.

जिस तिथि से स्वैछिक सेवा निवृति दी जानी है वह दिनांक अभी तक तय नहीं हो पायी है. वीआरएस देने की प्रक्रिया को प्रत्येक कंपनी अपने लिए अलग अलग तय करेगी.

वीआरएस देने के पीछे यह मानसिकता है कि कंपनियों के खर्च को कम किया जा सके. तथा इनमें से कुछ एक एजेंट के रूप में या ब्रोकर के रूप में कार्य करें जिससे कंपनियां बीमा अपने पास ही रख सकें. भविष्य में विपण्न के लिए दिये जाने वाले वेतन का आधार प्रत्येक पोर्टफोलियो की अलग अलग लाभ अर्जन करने की क्षमता होगी. जिससे अधिक से अधिक अच्छा बीमा लेखन किया जा सके.

ऐसे विकास अधिकारियों ने जिन्होंने वीआरएस के लिए आवेदन किया है वे किसी भी सार्वजनिक क्षेत्र की बीमा कंपनी के एजेंट बन सकते है. तथा 100 घंटे के पाठयक्रम से अपने अनुभव के आधार पर बचने के लिए प्रयासरत है.

योजना में कंपनी के संसाधन को को. ब्रोकर तथा कार्पोरंट एजेन्ट के लिए प्रयोग करने को कहा गया है साथ ही प्रबन्धन के खर्च को प्रीमियम आय के 19.4 प्रतिशत अनुपात तक लाने का प्रयास है जो बीमा अधिनियम 1938 की धारा 40 सी के अर्न्तगत जरूरी भी है.

जनरल इंशुरेन्स पब्लिक सैक्टर ऐसोसिएशन (जिप्सा) जो चारों कंपनियो के लिए वीआरएस की देखरेख कर रही है वह वर्ग 4 तथा वर्ग 1 के लिए भी इसी प्रकार से वीआरएस योजना बना रही है.

अमेरिका में कर्मचारियों को हैल्थ बीमा के लिए अधिक खर्च करना होगा

अमेरिका में बडे तथा छोटे व्यापार में लगें कर्मचारियों को हैल्थ बीमा के लिए अधिक खर्च करना होगा जिसका कारण बढते हुए प्रीमियम को प्रबन्धकों द्वारा अपने कर्मचारियों की तरफ मोड देना है.

राष्ट्रीय सर्वेक्षण के आधार पर जिसमें 600 बडे तथा छोटे व्यापार व्यापारों को सर्वे किया गया यह पाया गया कि अभी भी नियोक्ता अपने कर्मचारियों को हैल्थ बीमा उपलब्ध करवाने के लिए प्रतिबद्ध हैं लेकिन 92 प्रतिशत ने कहॉ कि अगले वर्ष से वे अपने कर्मचारियों से इस निधि में अधिक प्रीमियम देने को कहेगें.

सर्वेक्षण बताता है कि सभी आकार की कंपनियाँ 18 प्रतिशत अतिरिक्त प्रीमियम पिछले वर्ष की अपेक्षा लेना चाहती है. यह वर्ष 2002 में बढाये गये 14 प्रतिशत प्रीमियम के बाद होने जा रहा है. सर्वेक्षण के आधार पर कहा गया है कि प्रत्येक वर्ष औसत 17 प्रतिशत की दर से हैल्थ लागत में वृद्धि हो रही है.

सर्वे यह भी बताता है कि :

- 70 प्रतिशत नियोक्त कहते है कि बीमा आवरण के कर्मचारियों कि संख्या में अगले दशक में वृद्धि होगी
- लगभग सभी व्यापारों का कहना था कि कर्मचारियों से अपेक्षा कि जायेगी की वे अधिक हैल्थ बीमा प्रीमियम तथा सह प्रीमियम दें और ऐसा अगले पाचँ वर्ष तक निरंतर जारी रहने की संभावना है. इसके बावजूद की बढी हुई लागत का दो तिहाई हिस्से का वहन कंपनी स्वयं करेगी तथा केवल एक तिहाई लागत ही अपने कर्मचारियों को पास करेगी.
- बढती हुई लागत को सहन करने के लिए 45 प्रतिशत कर्मचारियों ने कहा वे अगले पाँच वर्षो में अपने हैल्थ लाभों को कम कर लेगें.
- केवल 4 प्रतिशत व्यापारियों ने कहा कि वे अपने कर्मचारियों के हैल्थ कवर को पूरी तरह छोडने वाले हैं. बढती हुई लागत को देखते हुए अगले पाँच सालों में ऐसे संस्थानों में जहाँ कर्मचारियों की संख्या 50 से कम है हैल्थ कवर के काफी कम हो जाने की आशा है.

अनुसंधान बताता है कि बच्चों, स्त्री, पुरूष के बीमित न होने पर चिंता होती है. गैरबीमित पुरूषों में अन्य की अपेक्षा कलोन कैंसर की संभावना दुगनी होती है. गैरबीमित महिलाओं के लिए यह स्थिति अधिक चिंताजनक है इनमें स्तन केंसर के कारण मौत की संभावना बीमित महिलाओं की अपेक्षा दुगनी होती है. गैरबीमित बच्चों में बच्चों के रोगो की संभावना जैसे कान के रोग की स्थिति लगभग दुगनी होती है.

बीमा सर्वेक्षक के संबन्ध में आईआरडीए के विनियम

संजीव जैन

यद्यपि भारत सरकार द्वारा 20 नवम्बर 2000 को बीमा सर्वेक्षक और हानि निर्धारक के संबन्ध म विनियम की अधिसूचना जारी की थी लेकिन अभी भी यह विनियम आम जनता में बहुत प्रचलित नहीं हो पाये हैं इनके प्रचलन के लिए हम यहां बीमा सर्वेक्षक और हानि निर्धारक के विनियम की मुख्य बाते आपके सामने प्रस्तुत कर रहे है.

जैसी की प्रथा है विनियमन के प्रथम अध्याय में प्रत्येक शब्द को परिभाषित किया गया है. अध्याय दो में अनुज्ञापन प्रक्रिया के संबन्ध में जो बातें कही गई है उनकी मुख्य विशेषताये निम्न लिखित है.

1. जो व्यक्ति एक वयष्टि है और साधारण बीमा कारोबार के संबंध में सर्वेक्षक और हानि निर्धारक के रूप में कार्य करना चाहता है उसे अनुसूची में दिये गए प्ररूप - बी.वि.वि.प्रा.-1- ए एफ में अनुज्ञप्ति के अनुदान के लिए प्राधिकरण को आवेदन करना होगा. प्राधिकरण अनुज्ञप्ति अनुदान करने से पूर्व, सर्वेक्षक और हानि निर्धारक के कर्तव्यों, उत्तरदायित्वों और कृत्यों से संबंधित सभी विषयों पर विचार करेगा और अपना समाधान करेगा कि आवेदक अनुज्ञप्ति अनुदत्त करने के लिए उपयुक्त और उचित व्यक्ति हैं. विशिष्टत: और पूर्वगामी पर प्रतिकूल प्रभाव डाले बिना, प्राधिकरण यह समाधान करेगा कि सभी प्रकार से पूर्ण आवेदन प्रस्तुत करने के अतिरिक्त आवेदक-

(क) अधिनियम की धारा 42 घ के साथ पठित धारा 64 पड और बीमा नियम, 1938 के नियम 56 क की सभी लागू अपेक्षाओं को पूरा करता है.

(ख) ऐसे अतिरिक्त तकनीकी अर्हताएं रखता है जो समय-समय पर प्राधिकरण द्वारा विनिर्दिष्ट की जाएं.

(ग) प्रवर्गीकरण पर आधरित अनुज्ञप्ति के अनुदान के लिए फीस के संदाय का साक्ष्य प्रस्तुत किया है,

(घ) इन विनियमों के अध्याय 7 में अन्तर्विष्ट 12 मास से अनधिक अवधि का व्यावहारिक प्रशिक्षण किया है.

(ड) ऐसी अतिरिक्त जानकारी प्रस्तुत करता है जिसकी प्राधिकरण द्वारा समय समय पर अपेक्षा की जाए.

प्राधिकरण से समाधान हो जाने पर कि आवेदक अनुज्ञप्ति के अनुदान के लिए पात्र है, इन विनियमों की अनुसूची में दिए गए प्ररूप- बी.वि.वि.प्रा.-2- एल एफ में उसका अनुदान करेगा और साधारण बीमा कारोबार में उस विशिष्ट वर्ग या प्रवर्ग का, अर्थात् अग्नि, समुद्री स्थोरा, समुद्री हल, इंजीनियरी मोटर, प्रकीर्ण और लाभ की हानि, जिसके लिए प्राधिकरण ने अनुज्ञप्ति की है, उल्लेख करते हुए एक पहचान पत्र के साथ आवेदक को संसूचना भेजेगा और अनुज्ञप्ति, जब तक कि उसे पहले द्द न किया जाए, उसके जारी करने की तारीख से पाँच वर्ष की अवधि के लिए विधिमान्य रहेगी.

कोई ऐसा सर्वेक्षक और हानि निर्धारक, जिसकी अनुज्ञप्ति किसी कारण से द्द या निलंबित की गई हो, ऐसे रद्धकरण या निलंबन की तारीख से तीन वर्ष की समाप्ति के पश्चात् अनुज्ञप्ति के जारी करने के लिए आवेदन प्रस्तुत कर सकेगा और ऐसे किसी आवेदन को नया मामला माना जाएगा और तद्नुसार आवेदक उपविनियम (2) की सभी अपेक्षाओ को पूरा करेगा. साथ ही कोई भी सर्वेक्षक और हानि निर्धारक इन विनियमों के अध्याय 5 में विनिर्दिष्ट प्रवर्गीकरण के अधीन होगा.

इन विनियमों के प्रारंभ के पूर्व बीमा नियंत्रक या उसके प्राधिकृत प्रतिनिधि द्वारा जारी की गई कोई अनुज्ञप्ति इन विनियमों के अनुसार जारी की गई समझी जाएगी.

निगमित सर्वेक्षक और हानि निर्धारक

जहाँ आवेदक कोई कंपनी या फर्म है, वहाँ प्राधिकरण श्यह समाधान करेगा कि यथास्थिति, सभी निदेशक या भागीदार अधिनियम की धारा 64 पड (1) घ (i) में विनिर्दिष्ट अर्हताओं में से एक या अधिक रखते हैं और यथास्थिति, ऐसे निदेशको या भागीदारों में से कोई भी अधिनियम की धारा 42 (4) के साथ पठित अधिनियम की धारा 42 घ में उल्लिखित निरर्हताओं में से किसी से ग्रस्त नहीं है. इन विनियमों की अनुसूची में दिए प्ररूप - बी.वि.वि.प्रा.-3 एएफ में आवेदन करेगा.

प्राधिकरण यह समाधान हो जाने पर कि आवेदक अनुज्ञप्ति के अनुदान के लिए पात्र है, इन विनियमों की अनुसूची में दिए गए प्ररूप - बी.वि.वि.प्रा.-4- एलएफ में उसका अनुदान करेगा और उपरोक्त विनियम 3 के सभी उपबंध, निगमित सर्वेक्षक को यथावश्यक परिवर्तनों सहित लागू होंगें.

कोई भी ऐसा अपूर्ण आवेदन, जो इन विनियमों की अपेक्षाओं के अनुरूप नहीं होगा नामंजूर किया जाएगा. परन्तु ऐसे किसी आवेदन को नामंजूर करने के पूर्व आवेदक को आवेदन पूरा करने के लिए युक्तिसंगत अवसर दिया जाएगा.

अनुज्ञाप्ति का नवीकरण

या तो इन विनियमों के अधीन या इन विनियमों के प्रारंभ के पूर्वतरअनुदत्त अनुज्ञप्ति को नवीकृत करने की वांछा करने वाला कोई बीमा सर्वेक्षक और हानि निर्धारक दो सौ रूपये की फीस के साथ इन विनियमों की अनुसूची में दिए गए प्ररूप - बी. वि. वि. प्रा.5. ए एफ (व्यष्टियों के लिए)/ प्ररूप बी. वि.वि.प्रा.-6- ए एफ (निगमित सर्वेक्षको के लिए) में उसकी विधिमान्यता की अवधि समाप्ति के कम से कम तीस दिन पूर्व प्राधिकरण को आवेदन करेगा.

परन्तु प्राधिकरण, यदि उसका यह समाधान हो जाता है कि अन्यथा असम्यक् कठिनाई होगी, तो आवेदक द्वारा सात सौ पचास की शास्ति के संदाय करने पर उसकी समाप्ति के छह मास के भीतर किसी आवेदन को स्वीकार कर सकेगा.

लेखक
उप निदेशक, आईआरडीए

बीमा भविष्यफल

संकल्पना - संजीव जैन
कला - शैलेश इजमुलवार

बीमा लोकपाल कैसे कार्य करता है

समीरन भट्टाचार्य

भारत में विभिन्न क्षेत्रों में शिकायतों का निपटान करने के लिए लोकपाल पद्धति का प्रयोग अपेक्षाकृत नया अध्याय है. हमारी अनेक राज्य सरकारों ने अपनी विधान सभा में अनेक विधेयक पारित किये है जिनका सम्बन्ध विभिन्न विभागों से है. अन्य अनेक विशिष्ट क्षेत्रों में भी लोकपाल को उतारा गया है.

विधायी कार्यवाही

अब बडे नगरों तथा महानगरों में बीमा लोकपाल के 12 कार्यालय कार्यरत हैं जिसके द्वारा देश के सभी राज्यों तथा संघ शासित प्रदेशों का संरक्षण प्राप्त है. बीमा लोकपाल का कार्यक्षेत्र पालसी जारी करने वाले कार्यालय के आधार पर जारी किया जाता है. सभी बीमा लोकपालों की नियुक्ति वरिष्ठ सेवानिवृति बीमा कार्यपालकों (जीवन तथा गैर जीवन) से की गई है जिसमें विधायिका ये जुडे तथा सिविल सेवा के लोग भी शामिल हैं

एक बीमा लोकपाल तीन तीन वर्ष कार्यावधियों के लिए नियुक्त हो सकता है अथवा 65 वर्ष की आयु जो भी पहले हो में सेवानिवृत हो जाता है. प्रत्येक बीमा लोकपाल की सहायता के लिए विभिन्न सार्वजनिक उपक्रमों के कार्य पालकों की प्रतिनियुक्ति की जाती है.

भारतीय जीवन बीमा निगम आवश्यक ढांचा तथा दैनिक खर्च उपलब्ध करवाता है (जो दिये गयी प्रक्रिया के अनुसार सभी बीमा कंपनियों द्वारा बाँटा जाना चाहिये) तथा गैर जीवन बीमा के लिए प्रत्येक सार्वजनिक क्षेत्र कंपनी को जाने कि जिम्मेदारी है जिसके अनुसार प्रत्येक जोन में कार्य विशेष स्थापित है.

प्रक्रिया

किसी भी शिकायत को प्राप्त करने के बाद बीमा लोकपाल का कार्यालय देखता है कि क्या इसका पंजीकरण नियम 12 व 13 आर पी जी नियमों के अनुसार किया जा सकता है तथा शिकायतकर्त्ता को एक निश्चित तिथि तक सम्बन्धित सूचना तथा दस्तावेजों की प्रतिलिपि जमा करवानी होती है यदि आवश्यक हो तो दोनों पार्टियों को वार्तालाप के लिए बुलाया जाता है.

बीमा लोकपाल के पास बढती हुई बीमा शिकायतों के पुलिंदे का प्राथमिक कारण यह है कि निपटान बहुत द्रूत है

(और जहाँ तक दावेदार का प्रश्न है बीमा लोकपाल मामलों के लिए खर्च नगण्य है)

पहली कोशिश के रूप में बीमा लोकपाल मध्यस्थता करते हुए नियम 15 के अनुसार शिकायत का समाधान प्रस्तुत करता है . यदि यह संभव न हो वह एक अवार्ड घोषित करता है जो लागत तथा खर्च के अनुसार नियम 16 के अनुसार 20 लाख से ज्यादा नहीं हो सकता.

यदि यह अवार्ड शिकायतकर्त्ता को मान्य न हो व उपभोक्ता अदालत में अपनी नई शिकायत धारा (2) उपभोक्ता संरक्षण अधिनियम 1986 के अन्तर्गत दे सकता है अथवा किसी संबधित कोर्ट में सिविल प्रक्रिया के अन्तर्गत अथवा उपभोक्ता संरक्षण अधिनियम साथ साथ लिमिटेशन अधिनियम 1963 के अन्तर्गत याचिका दायर कर सकता है.

यदि कोई शिकायत आरपीजी नियम (नियम 12 व 13) को पूरा नहीं करती तो बीमा लोकपाल का कार्यालय शिकायत दर्ज करने में अपनी असमर्थता की सूचना दे सकता है. उदाहरणतः यदि कोई शिकायत किसी उपभोगता संरक्षण अधिनियम 1986 की धारा 12 अथवा किसी न्यायालय में कोई याचिका दर्ज की गई हो जो भारतीय सिविल संहिता से संचालित होती है अथवा आरबीट्रेटर जोकि आरबीट्रेशन तथा कंसीलियेशन

अधिनियम 1986 से संचालित होते है. ऐसी अवस्था में बीमा लोकपाल ऐसी शिकायतों को नही ले सकता.

बीमा लोकपाल के समक्ष कोई शिकायत लाने के लिए समय अवधि निर्धारित है जो बीमा कंपनी के द्वारा अंतिम उत्तर दिये जाने के बाद एक वर्ष तक होती है. अंतिम उतर से अभिप्राय है बीमा दावे निपटान पर बीमित के प्रतिवेदन पर बीमा कंपनी का निर्णय है.

बीमा लोकपाल का कार्यालय बीमा कंपनी का दावा निपटान विभाग नहीं है इसलिए बीमा कंपनी को दावे के निपटान पर पहले निर्णय लेना होगा और दूसरे विकल्प के रूप में बीमा कंपनियों को बीमित के प्रतिवेदन पर विचार करना होता है उसके बाद ही बीमालोकपाल की भूमिका प्रारंभ होती है. लोकपाल दावों को उनके स्तर के आधार पर तथा उन दस्तावेजों के आधार पर जिसके आधार पर बीमा कंपनी ने निणर्य लिया तथा साथ ही दोनों पक्षों की मौखिक अभिव्यक्ति के आधार पर निर्णय लेते हैं.

बीमा लोकपाल के लिए दावे को निर्धारण करने के उपर अपनी राय देने के लिए एक माह तथा अवार्ड देने के लिए तीन माह का समय निर्धारित किया गया है.

बीमा लोक पाल के समक्ष आने वाले मामलों में निरंतर वृद्धि हो रही है इस कलैंडर वर्ष में इनके 10,000 से उपर पहुँच जाने की आशा है.

प्राथमिक कारण है अंतिम तथा जल्द समाधान (जहाँ तक दावेदारों को संबन्ध है) लोकपाल के यहाँ शिकायत करने पर कोई खर्च नहीं उठाना पडता इसके विपरित औसत पाँच वर्ष का समय तथा बहुत से खर्च लगते है यदि मामलो को उपभोकता अदालत की तरफ ले जाया जाए तथा वहॉ हमेशा यह संभावना बनी रहती है कि निपटान में देरी हो दूसरी तरफ पारंपरिक रूप से न्यायालय में केस तयर करने के लिए स्टाम्प फीस तथा औसत पाँच साल का समय जो बढ भी सकता है. यहाँ तक की की आरब्रिटेशन की फीस को बाँटना पडता है.

जल्द निपटाने तथा बिना खर्च के अतिरिक्त कार्य के निणर्य की पद्वति परिदृश्य है यह इस कारण है कि यह प्रणाली सेवा देने वाले कि रक्षा करती है जो बीमा क्षेत्र से है और उन्हें अच्छा अनुभव है तकनिकी क्षेत्रों का विभिन्न कार्यालयों तथा विभिन्न संवर्गो में काम कर सकने का अतः वह मामले की विषय वस्तु को ठीक दिशा में समझ सकते हैं. बीमा लोकपाल के कुछ कार्यालयों में एक और अच्छी बात है वह यह है कि तकनिकी कानूनी विशेषज्ञों की बीमा उद्योग से नियुक्ति की गई है.

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बीमा लोकपाल कार्यालय, मुंबई

लम्बा रास्ता

-साधारण बीमा में नियुक्त बीमांकक

अपर्ण एन थानावाला

बीमा विनियामक तथा विकास प्राधिकरण आईआरडीए द्वारा बनाये गये नियुक्त बीमांकक विनियम ने भारत में साधारण बीमा कंपनियों में बीमांकक की भूमिका पैदा कर दी है. इन विनियामको के अनुसार साधारण बीमा कंपनियों में नियुक्त बीमांकक एक बीमांकक एक कर्मचारी हो सकता है या परामर्श बीमांकक हो सकता है.

इस लेख का उद्देश्य नियुक्त बीमांकक की भूमिका की परीक्षा करना तथा उससे भारत में क्या अपेक्षाएँ हैं उसका प्रशिक्षण करना है उसके समक्ष क्या क्या चुनौतियॉ है तथा क्या क्या रास्ते हैं.बीमा विनियामक तथा विकास प्राधिकरण आईआरडीए द्वारा जीवन बीमा उद्योग के लिए बनाये गए नियुक्त बीमांकक से साधारण बीमा के लिए कार्यरत बीमांकक की भूमिका बहुत अलग नहीं है विशेष रूप से नियुक्त बीमांकक की जिम्मेवारी है कि वह पालसी होल्डर के हितों की रक्षा करें तथा विनियामक के लिए प्रहरी का काम करें.

विनियामक के अनुसार साधारण बीमा के नियुक्त बीमांकक के लिए निमन लिखित बातें रखी गई हैं.

- प्रबन्ध को बीमांकक विशेष रूप से उत्पाद, आकार, दर तथा पुर्नबीमा के सम्बन्ध में परामर्श प्रदान करना.
- बीमाकर्त्ता के शोधन क्षमता का ध्यान रखना.
- गैर टैरिफ व्यापार के लिए प्रीमियम दरों को प्रमाणित करना.
- मजबूत बीमांकक सिद्धांतो के आधार पर अरक्षितों की गणना करना
- नियुक्त बीमांकक की अधिकांश जिम्मेवारियॉ पालसी होल्डर के आसपास निम्न लिखित बातों से पूरी हो जाती है.
- बीमा कर्त्ता की देयता को निर्धारित करना तथा शोधन क्षमता को पक्का करना तथा लगातार समझौते में दी गयी शर्तो से बंधित रहना (आरक्षित को प्रमाणित करना)
- बेचे गए विभिन्न प्रकार के उत्पादों को नियन्त्रित करना तथा उन उत्पादों की दरों को ठीक प्रकार निर्धारित करना (आईआरडीए) में उत्पादों को फाइल करना बीमांकक प्रमाणिकरण करते हुए तथा उचित दर पर
- आपातकालिक परिस्थितियों के लिए ऐसे प्रबन्ध करना जिससे बीमा लेखन के दायरे में बीमाकर्त्ता द्वारा पुरा किया जा सके ऐसे समय में भी जब बीमाकर्त्ता वित्तिय सम्स्याओं से आत्मसाध हो रहा हो (प्रत्येक समय शोधन क्षमता अनुपात को मोनिटर करना तथा बनाए रखना)
- इसके अतिरिक्त नियुक्त बीमांकक प्रबन्धको को उनके वित्तिय लक्ष्य प्राप्त करने में भी मदद प्रदान कर सकता है .
- अन्य क्षेत्र जहॉ नियुक्त बीमांकक एक अहम् भूमिका अदा कर सकता है
- वैसे यह विनियामक में परिलक्षित नहीं हुआ है वह है सूचना प्राद्योगिकी

> अन्य क्षेत्र जहॉ नियुक्त बीमांकक अहम् भूमिका अदा कर सकता है वैसे यह विनियामक में नहीं आता वह है सूचना प्राद्योगिकी प्रणाली की योजना तथा अनुपालन करना

- प्रणाली की योजना तथा अनुपालन एक बीमांकक एक विशिष्ट स्थिति में होता है जिससे वह प्रणाली की क्षमताओं का दोहन करवा सके और इसके आधार पर प्रणाली को विकसित करने में महत्वपूर्ण भूमिका अदा कर सकता है.

चुनौतिया: भारत में साधारण बीमा कंपनी के नियुक्त बीमांकक को अनेक चुनौतियों का सामना करना पडता है इनमें से कुछ के विवरण अधोलिखित है.

पहले और सबसे महत्वपूर्ण आकडों का ऐसे वर्गीकरण के रूप में उपलब्ध होना है जिसे बीमाकंक अपनी जॉच पडताल के लिए प्रयोग कर सके जिससे प्रीमियम दरों तथा तकनिकी आरक्षियों का निर्धारण किया जा सके बीमांकक को प्रत्येक वर्ग के लिए सांख्यकी की जरूरत पडती है इसी के आधार पर बीमांकक विभिन्न औजारो का प्रयोग करते हुए मान्यताओं और पद्वति का प्रयोग करते है. एक उचित प्रीमियम दर का निर्धारण करता है जिससे निर्धारित तकनिकी आरक्षितियों तक पहुचॉ जा सकता है और इसकी निपूर्णता इस बात पर निर्भर करती है कि उपलब्ध करवाये गये आकडें कितने प्रमाणिक है.

भारत में वर्ष 2000 में बीमा उद्योग करे खोलने से पहले साधारण बीमा उद्योग में बीमांकक की भूमिका बहुत कम थी. भारतीय साधारण बीमा निगम जीआईसी और इसकी चारों सहायक कंपनियों द्वारा प्रीमियम दरों का निर्धारण तथा पुनःनिर्धारण के लिए बीमांकको पर निर्भर नहीं थी तथा पूर्व हानि दावा के आकडों को विभिन्न वर्गो और संवर्गो के अनुसार एकत्र करने में ज्यादा ध्यान नहीं दिया जाता था तथा अवधि तथा अनुभव पर भी ज्यादा ध्यान नही दिया जाता था.

इससे आगे नयी निजी बीमा कंपनियों ने अपना कारोबार अभी प्रारंभ किया है इसलिए उनके पास पूर्व आकॅडे उपलब्ध नहीं है और उद्योग के अनुसार ऑकडे भी नही है जिन पर निर्भर रहा जा सके.

एक बीमा कर्त्ता को अपने लम्बे समय के लाभ लक्ष्यों को प्राप्त करने के लिए सभी संवर्गो के व्यापार के लिए पक्की दरों का आधार मजबूत सैद्वांतिक बीमा कंपनियों से हो सकता है तथा पोटफोलियों लेखन तथा बदलती सामाजिक, आर्थिक परिस्थितियों के साथ वैधानिक तकनीकी वातावरण के बदलाव से है. इसके लिए दरों में चुनाव में सावधानी आवश्यक है यह ऐसे कारक है जो बीमा जनसंख्या के सह विभाजन को अपने जैसे ही वर्गो के लिए उचित दरे रखते हैं. यह वर्तमान में भारत में नही हो रहा है. मोटर वाहन प्रीमियम का उदाहरण ले जिसका आधार सरकारी कंपनियॉ है वह इंजन के साईज आधार पर दर निर्धारण करते है जबकि इसके लिए अन्य अनेक काण उत्तरदायी है जो जोखिम को बढाते या घटाते है. ब्रिटेन में दरो का आधार इंजन का साईज, कवर का प्रकार, वाहन प्रयोग क्षेत्र, वाहन की आयु तथा पालसी होल्डर का रिकार्ड होता है.

लेखक बीमांकक सलाहकार तथा पार्टनर थानावाला कंसलटेंसी सर्विस, मुंबई

Dealing with Disaster

Susan was going home for Christmas, her first after getting a new job with the IRDA. On December 21, she boarded a train from Hyderabad to Bangalore and went to sleep thinking of all the folks who would have gathered back home for the holidays.

The next thing she knew she heard metal screeching and the train came to a halt. In the pitch dark and in the middle of nowhere.

In minutes everyone clambered down from their berths and stood on the aisles holding on to their luggage. Speechless and terrified, they could feel their bogie was not on the level. Derailment?? And the next thought was, what if we are on a bridge? It was pitch dark outside and there was no way to be sure.

And then they heard it. The wailing and the screaming. Luckily Susan's compartments was a safe way behind the ill-fated ones near the engine that bore the brunt of the accident.

There was not only no habitation in sight, there were no lights and no clue about where they could be. First aid, trained rescue workers and medical attention were worlds away even in imagination.

For the unfortunate ones help came slowly, and for some it came too late. Before it could be determined where they were stranded and how they could be moved to a hospital. Twenty one died and over a hundred were injured.

The beauty of the moment was the human spirit to overcome terror and help. Those in the safe compartments hurried to help the injured. Volunteers formed groups with leaders emerging instantaneously, rescuing petrified children, dazed men and women, and in some cases extricating lifeless bodies. Some cell phones were whipped out and doctors summoned – all by on the spot, spur of the moment, thinking.

The same agony and lack of a systematic rescue plan was reflected as volunteers and railway workers who arrived there in about an hour's time struggled to shift the injured out of the wreckage and to the nearby hospitals. It was not quite clear where the nearest suitable hospital was…. or the quickest way to the nearest road…..

And what they lacked in information, equipment and fancy gadgets they made up for with solicitousness and a rough readiness to work.

After several nightmarish hours Susan went home to a huge welcome in Bangalore station after midday the next day, and to a very grateful Christmas indeed.

The work that Professor I. V. Muralikrishna and his team have been doing is bound to give better control when such traumatic situations occur, and to make things less chaotic and helpless, if not less painful, to those involved.

The Professor is Head of the Centre for Spatial Information Technology (CSIT) of the Jawaharlal Nehru Technological University (JNTU), Andhra Pradesh, and has created a pilot Disaster Management Information System as part of its work for South Central Railways' Decision Support System.

Using information technology to interpret satellite images of various terrains – in this case of stretches of land adjoining railway tracks – the team used geographical information systems and global positioning systems to map railway routes. The output is a map of the terrain to help in the quick identification of accident spots.

This would put emergency inventory information (like nearby habitation, hospitals, police and other agencies, telecommunication and transportation facilities and so on) at the fingertips of rescue and recovery workers within a crucial few minutes once man-made disasters happen.

Using this captured data as background, the control room which will be established by the railways as part of the system, for instance, can at the click of a mouse get information on the topography of the accident site, assess the extent of the damage, arrange appropriate rescue resources, prioritise rescue works and arrange for quick and efficient site clearance and traffic diversions according to need.

The pilot project has mapped a 150 km rail route between Secunderabad and Bhongir. A similar study of the airline route between Hyderabad and Chennai has been done, the latter on behalf of the Electronics Corporation of India Limited (ECIL) who in turn is working with the Airports Authority of India. In the Aircraft Disaster Management project, topographical features like water bodies and forests are marked out since rescue operations have to take into account a scattering of debris over a large area.

The studies have mapped details like the number of hospital beds available in a certain radius, distance and links to the nearest road and telecommunications facilities and even stores information on the local administration like telephone numbers of local level revenue and police officials who should be contacted in an emergency.

The CSIT, once its pilot project is fine tuned and approved, will be able to pass on the methodology to commercial players who could be chosen to execute the full fledged project.

What we need all over the country is a well thoughtout rescue and recovery plan for disasters and an action plan for on the ground personnel to follow, and an effective control room that has all the information it needs to instruct them on a real-time basis.

Instead what we do today is stare helplessly at television images of people dying at accident sites and helpless and poorly directed rescue workers.

And with that mix of topographical and administrative data and the quick and natural helping instincts of people during a disaster, we should be able to deal with disaster when things go out of control.

Funding Nature's Fury

They happen with unfailing regularity earthquakes, floods and cyclones and we all but forget the loss of lives and property, the helplessness and the desperation they leave behind. Till nature's fury strikes again.

Natural disasters happen all over the world but nowhere are their effects as, well, disastrous, as on an unprepared economy.

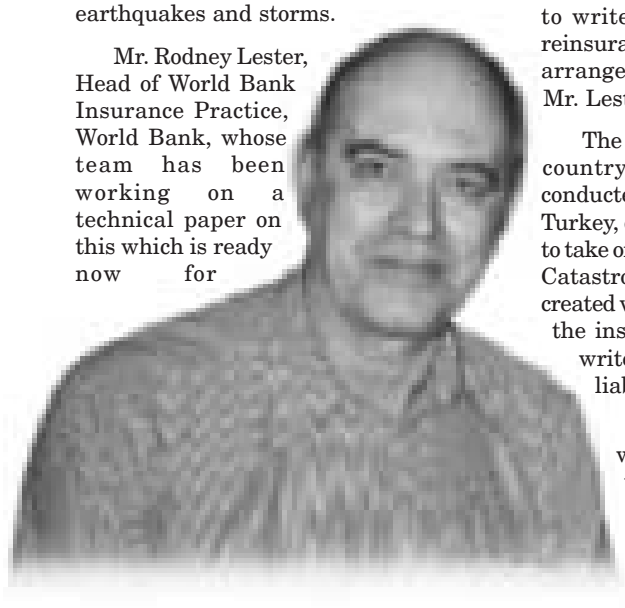
When coping with the after-effects of disasters, one looks back to find that it's not so much the prosperity of the nation (though that matters) or the forecast of the disaster that makes such a difference as much as preparedness.

Preparedness both physical and financial. What it takes to carry out swift rescue and recovery operations to save as much damage to property and life as possible, and also financial planning and ability to rebuild what was destroyed.

In fact if we begin at the beginning, we in India don't even have a clear idea of what kinds of natural disasters we are vulnerable to in different parts of the country.

And this is where the first step is to be taken.

The World Bank has come out with a new product – Natural Disaster Insurance – which envisages creating a financing mechanism for dealing with losses due to rapid onset natural disasters like earthquakes and storms.



Mr. Rodney Lester, Head of World Bank Insurance Practice, World Bank, whose team has been working on a technical paper on this which is ready now for clearance by the Indian Government told **IRDA Journal** that he hoped that this would lead to the making of a policy on dealing with natural disasters.

The policy would look at disaster profiling, disaster planning and asset allocation in the case of disasters and also work out ways by which to cover vulnerable sections of the society.

The process aptly starts off with risk profiling. State governments that wish to participate would be required first to map their risk profiles to study their actual loss potential. This, compared to what capacity each state has to bear the losses, would show the level of financial preparedness in the case of such losses.

For instance, state and Central governments feel implicitly responsible for replacing housing. If a system was evolved whereby all those who could afford insurance for their housing property did purchase it, then the finite resources of the governments could be directed towards the more vulnerable sections of the society to replace their housing infrastructure, and to repair and replace public infrastructure like roads and bridges.

The World Bank's approach paper started out being on South Asia but turned out to be an Indian study. And the good news is that the bulk of risk problems here can be dealt with through insurance.

The Indian market has the capacity to write these risks and can resort to reinsurance and can even study a pooling arrangement within the industry, says Mr. Lester.

The insurance industry in the other country where a similar exercise was conducted recently, the earthquake-prone Turkey, did not have the internal capacity to take on the risks there and so the Turkish Catastrophic Insurance Programme was created whereby the companies distributed the insurance as a product but did not write the risk on their and but had the liabilities funded centrally.

"The trick in India is to find a way to fund it," says Mr. Lester, who has been with this programme for five years after a career with the life insurance industry in Australia with the AMP group.

Some of the suggestions for funding were to collect the premiums for natural disaster insurance as part of municipal (property) tax, or as a surcharge at the time of transfer of property or when a property is mortgaged.

The IRDA has suggested that collecting it along with the municipal taxes on property would be the better option as it takes into account affordability (of owning property and hence of paying premium to protect it) and periodic collection and that insurance companies should offer disaster cover along with fire as an optional extra.

"We are thinking of suggesting to the centre and states that everyone who owns property should have a fire cover, Mr. N. Rangachary, Chairman IRDA said, and Mr. Lester agrees. "It has to be made mandatory to make it work," and the challenge is to administer the collection of the premiums smoothly letting the state government take care of the premiums under a group insurance scheme with the commercial insurance industry for sectors that cannot afford it. This premium was likely to come to about Rs. 60 crores for a state per year.

The World Bank, apart from creating the approach paper and working on Government clearance, is also willing to put up the reinsurance premiums for the pool as a contingent debt facility so that it survives the crucial first few years. That is, if the pool runs out of money to pay reinsurance premiums, the World Bank will step in and fund it.

As part of this process, a pilot study was done on the loss potential in four Indian states Andhra Pradesh, Gujarat, Maharashtra and Orissa by RMSI, a global IT company. The assessment pertained to risks to housing and public infrastructure assets due to natural disasters like flood, earthquakes and cyclones.

The idea of the mapping was to assess the post-disaster funding mechanisms in the region including catastrophe insurance and reinsurance arrangements.

If the project goes through and there is a higher awareness about the need to insure property the dismal scenes of cyclone or storm damage need not in future carry with them the heartrending spectre of financial doom.

Report Card:GENERAL

The non-life insurance industry had two new entrants in the private sector during the financial year 2002-03, namely, Cholamandalam General Insurance and HDFC Chubb General Insurance. The public sector Export Credit and Guarantee Corporation (ECGC), which has been carrying on business for many years now got itself registered with the IRDA during the year.

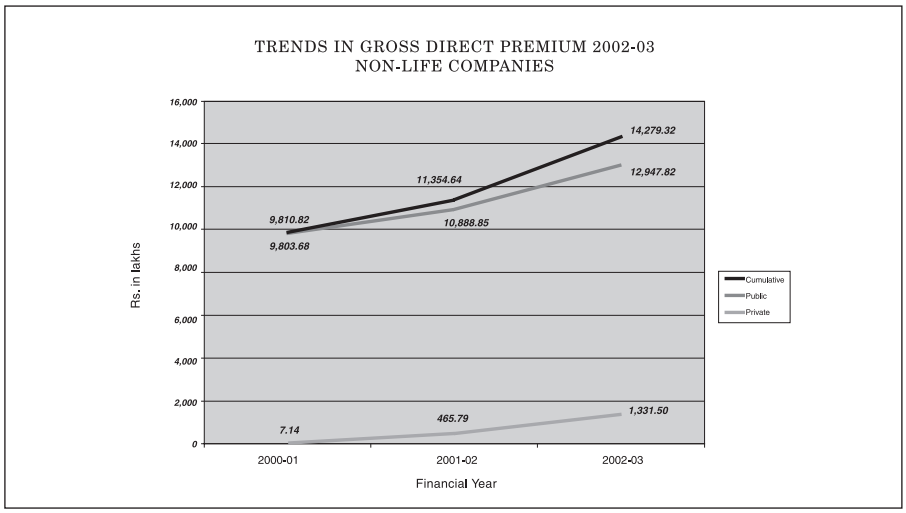
The total premium earned by the general insurance industry in the year 2002-03 was Rs. 1,42,79.32 crores (including ECGC which earned a premium of Rs. 376.03 crores) against Rs. 11,354.64 crores in 2001-02, which figure excludes ECGC.

Of this the public sector insurers (including ECGC claimed a market share of 90.68 per cent against a share of 96.24 per cent last year. The private sector had a share of 9.32 (3.76) per cent.

Of the total business Motor premiums came to Rs. 5,419.95 crores, or 38 per cent of total premiums. The public sector earned Rs. 5,038.16 crores out of this and it accounted for 39 per cent of their total business. The private sector wrote Rs. 381.79 crores worth Motor business accounting for 31 of their portfolio.

The Fire business brought in Rs. 2,969.13 crores or 21 per cent of the premiums of the industry. Of this the public sector share was Rs. 2557.22 crores or 19.75 per cent of its portfolio and that of the private sector Rs. 411.91 crores accounting for 29 per cent of its portfolio.

Health insurance premiums stood at Rs.861.94 crores or 6 per cent of the premiums of the entire industry. Of this, the public sector wrote Rs. 962.77 crores worth of business making up 6.02 of their portfolio and the private sector Rs. 82.34 crores which was 6.18 of their business. Here are detailed statistics of the general insurance industry.

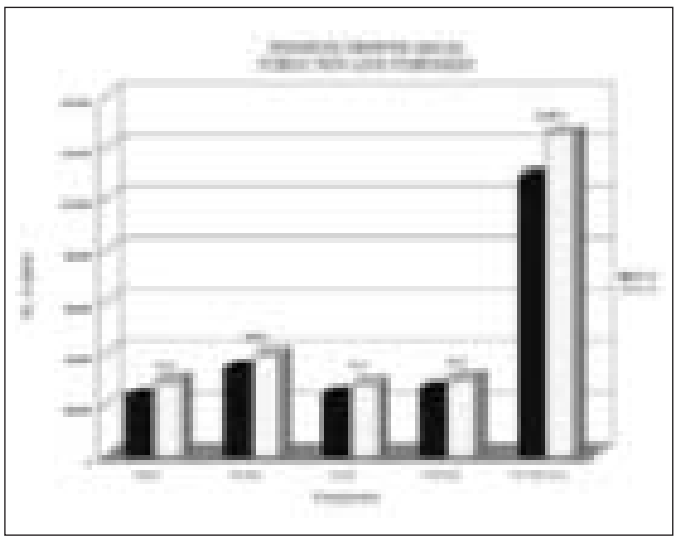


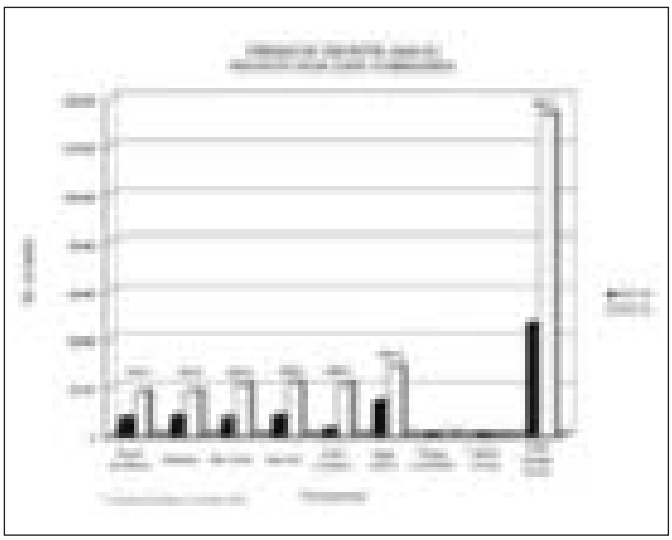
MAJOR BUSINESS SEGMENTS

(Rs. in lakhs)

Sl No.	Particulars	Premium u/w	% u/w *
I	Private Sector		
	Fire	41,191.16	30.94
	Marine (Cargo+Hull)	8,317.20	6.25
	Motor	38,179.31	28.67
	Engineering	12,805.80	9.62
	Health	8,234.34	6.18
II	Public Sector		
	Fire	2,55,721.87	19.75
	Marine (Cargo+Hull)	1,12,274.83	8.67
	Motor	5,03,815.95	38.91
	Engineering	59,080.82	4.56
	Health	96,277.04	7.00
III	Combined (I+II)		
	Fire	2,96,913.03	20.79
	Marine (Cargo+Hull)	1,20,592.03	8.45
	Motor	5,41,995.26	37.96
	Engineering	71886.62	5.03
	Health	104511.38	7.32

* % of total premium within private/ public/ combined figures





Gross Premium Underwritten 2002-03 (Provisional)

(Rs. in lakhs)

S.No.	Insurer	Premium	No. of Policies	Mkt Share %
1	**Royal Sundaram**			**1.27**
	Fire	3,826.51	17,425	
	Marine-Cargo	1,298.24	3,602	
	Engineering	1,306.98	561	
	Motor	8,471.66	2,18,991	
	Health	953.48	23,271	
	Liability	156.62	261	
	Personal Accident	1,885.16	44,005	
	Others	278.63	4,223	
	TOTAL	18,177.28	3,12,339	
2	**Tata AIG**			**1.55**
	Fire	3,172.01	4,078	
	Marine-Cargo	2,613.22	2,805	
	Engineering	2,956.19	644	
	Motor	7,721.97	81,026	
	Health	3,282.05	91,700	
	Liability	2,360.19	293	
	Others	87.31	3,226	
	TOTAL	22,192.94	1,83,772	
3	**Reliance**			**1.30**
	Fire	5,481.50	4,333	
	Marine Cargo	834.07	3,012	
	Marine Hull	57.47	2	
	Engineering	1,551.55	792	
	Motor	755.03	13,853	
	Health	517.80	934	
	Aviation	424.57	46	
	Liability	1,287.68	791	
	Marine Energy	5,949.52	4	
	Other Miscellaneous	1,635.69	4,864	
	TOTAL	18,494.88	28,631	
4	**IFFCO-Tokio**			**1.50**
	Fire	10,411.90	11,242	
	Marine Cargo	1,389.77	8,234	
	Marine Hull	453.47	18	
	Engineering	2,733.14	1,408	
	Motor	2,568.33	1,01,448	
	Health	954.30	12,578	
	Liability	392.29	729	
	Personal Accident	1,119.65	2,559	
	Others	1,389.84	8,343	
	TOTAL	21,412.69	1,46,559	
5	**New India**			**27.52**
	Fire	87,722.00	10,19,505	
	Marine Cargo	18,975.00	5,03,085	
	Marine Hull	15,129.00	15,690	
	Engineering	14,500.00	85,35,922	
	Motor	1,54,060.00	9,29,820	
	Health	39,000.00	9,55,767	
	Aviation	13,050.00	125	
	Liability	1,210.00	33,752	
	Others	49,254.00	24,68,132	
	TOTAL	3,92,900.00	1,44,61,798	
6	**Oriental**			**19.49**
	Fire	52,821.03	7,07,803	
	Marine Cargo	13,639.62	1,72,480	
	Marine Hull	9,077.74	6,439	
	Engineering	15,938.19	59,067	
	Motor	1,04,391.15	49,35,319	
	Health	18,695.84	4,00,190	
	Aviation	23,444.15	1,371	
	Others	40,233.40	16,81,204	
	TOTAL	2,78,241.12	79,63,873	
7	**National**			**20.23**
	Fire	53,544.84	6,14,053	
	Marine Cargo	16,276.87	2,28,990	
	Marine Hull	6,035.60	5,386	
	Engineering	13,617.63	1,20,443	
	Motor	1,28,310.80	50,88,805	
	Health	20,264.20	5,22,910	
	Aviation	6,888.81	1,002	
	Liability	3,052.77	45,205	
	Crop Insurance	6.29	4	
	Others	40,918.18	16,48,405	
	TOTAL	2,88,915.99	82,75,203	
8	**United India**			**20.81**
	Fire	61,634.00	13,45,133	
	Marine Cargo	15,556.00	1,85,085	
	Marine Hull	17,585.00	4,455	
	Engineering	15,025.00	3,14,352	
	Motor	1,17,054.00	48,79,052	
	Health	18,317.00	1,78,050	
	Aviation	2,503.00	26	
	Liability	2,567.00	74,473	
	Crop Insurance	107.00	1,232	
	Others	46,774.00	25,24,599	
	TOTAL	2,97,122.00	95,06,487	
9	**ICICI Lombard**			**1.51**
	Fire	13,149.82	38,820	
	Marine Cargo	614.20	1,672	
	Marine Hull	300.35	12	
	Engineering	2,300.04	703	
	Motor	281.13	3,214	
	Health	1,341.68	799	
	Aviation	138.33	16	
	Liability	134.90	103	
	Special Contingency	10.22	31	
	Others	3,250.89	52,923	
	TOTAL	21,521.56	98,293	
10	**Bajaj Allianz**			**2.03**
	Fire	4,605.17	19,166	
	IAR	902.87	459	
	Cargo	739.46	9,783	
	Hull	0.14	1	
	Motor	17,174.23	6,65,150	
	Engg	1,784.42	2,087	
	Health	1,062.99	16,483	
	Aviation	57.17	10	
	Travel	906.58	68,060	
	Special Contingency	408.88	719	
	Miscellaneous	1,286.58	37,272	
	TOTAL	28,928.49	8,19,190	
11	**Cholamandalam**			**0.1**
	Fire	544.25	613	
	Cargo	16.81	192	
	Engg	173.48	67	
	Motor	317.99	23,875	
	Health	122.04	1,445	
	Liability	273.40	49	
	Crop Insurance	1.63	1	
	Others	28.19	891	
	TOTAL	1,477.79	27,133	
12	**HDFC Chubb**			**0.07**
	Motor	888.97	17,533	
	Personal Accident	2.23	6	
	Others	52.78	23	
	TOTAL	943.98	17,562	
13	**ECGC**			**2.63**
	Export Credit Insurance	37,603.00	10,779	
	TOTAL	37,603.00	10,779	
	GRAND TOTAL	**14,27,931.72**	**4,18,51,619**	

Service Tax Riddles

R. Anand

The Government of India is committed to expanding the range and scope of service tax. The budget for 2003-04 envisages a collection of Rs. 8,000 crores under this head for 2003-04 from the existing level of Rs. 6,000 crores.

Right from 1994, when the Service Tax Act came into operation to cover a few services like telephone, insurance and advertising, its coverage has been expanded year after year to include services like marriage halls, beauty parlours, dry cleaners and event management.

Finance bill 2003-04 has further enlarged the range of services to include coaching centres, annual maintenance contracts, internet cafés, franchise services and so on. There is a school of thought that in an attempt to garner resources via services, we are biting off more than we can chew. There is also a feeling that service tax should be restricted to high volume services like telephone and insurance, and that other unorganised services which are sought to be covered should be left out, if not for anything else, because of the impossibility of administration.

The levy of service tax on general insurance premiums poses its own share of practical problems.

Sub-clause (d) of Clause 104 of Section 65 of Finance Act,1994, defines a taxable service as including any service provided to a policyholder by an insurer carrying on general insurance business.

Sub-clause (zl) of Clause 104 of Section 65 of Finance Act, 1994, defines a taxable service in relation to insurance auxiliary services to include service to a policyholder or insurer, by an actuary or intermediary or insurance intermediary or insurance agent, in relation to insurance auxiliary services concerning general insurance business.

Section 66 (1) levies a tax at the rate of 5 per cent (now proposed to be increased to 8 per cent) on the value of taxable services rendered in respect of various types of services.

Section 67 states that for the purposes of levy, the value of any taxable service shall be the gross amount charged by the service provider for such service rendered by him.

It may also be pertinent to note that the Finance Bill, 2003, by a notification (2/2001 dt.1.03.2003) has rescinded the earlier notification No.6/99 dt.9.4.91. As a result the exemption granted to premium received in convertible foreign exchange from the levy of service tax will no longer be applicable.

There is a feeling that service tax should be restricted to high volume services like telephone and insurance, and that other unorganised services which are sought to be covered should be left out, because of the impossibility of administration.

On a close reading of the above provisions various issues surface on the method and procedure to be adopted in collecting and paying service tax on general insurance business.

Issues

First and foremost it should be noted that in relation to general insurance business, the responsibility to collect and remit service tax and file the return of service tax rests with the insurer. In other words, the insurer, while selling the insurance policy, has an obligation to collect and pay service tax and thereafter file the return of service tax. However, in respect of agency services also, strangely, the responsibility to collect and pay service tax rests in the hands of the insurer notwithstanding the fact that the agent is responsible for selling the policy to the end customer. This is made clear in the Notification No. 5/2001-ST dated 9.7.2001.

The second issue that arises is: at what point of time does the liability to pay service tax crystallise.

Is it (a) at the time of commencement of the risk or (b) at the time of collection of the premium or (c) at the time of accounting of the premium? Another twist to the problem will be what will happen if the premium (particularly for big projects) is collected in installments over the period of 2 or 3 years?

The language of the provisions does not provide clear-cut answers to this question. But from a commercial standpoint, it appears that the application of service tax is inextricably linked to the commencement of risk.

It is also settled in several income tax cases that the method and manner of recording entries in the books of accounts is irrelevant to determining the taxability or otherwise of a transaction. Therefore, it is to be noted, that in general insurance business, service tax will have to be collected and paid in consonance with the commencement of the risk though it may not be practicable in all cases.

However, there is also a view that where premium under a policy is to be collected in instalments, the liability to tax arises only on the premium becoming due. But it is to be noted that in the case of service tax, the liablity is linked not to the payment of the fees but to the rendering of the service.

It is better that a clarification is issued by the authorities to dispel any doubts on the matter.

The third issue is an associated matter where a bank guarantee is

obtained for an insurance contract. In a typical bank guarantee, the bank concerned assures payment of the premium on behalf of the insured in case of a default. However, the insurer is obliged to pay service tax at the threshold itself when the risk commences. This will land the insurer in a tricky and difficult situation where the collection of service tax will come at a later point of time when the guarantee is invoked or the insured pays the premium, but the insurer has to pay the service tax upfront from his own funds.

The fourth issue on the matter is how will service tax apply in respect of co-insurance contracts. The lead insurer is like a captain of a cricket team. He takes overall responsibility for the policy in which he is the leader. While the co-insurers to the policy are legally and factually service providers to the insured apart from the lead insurer, the responsibility of paying service tax in reality lies in the sole hands of lead insurer.

This, it is admitted, is a matter of industry practice and does not surface from a reading of the Service Tax Act. Legally, it is still possible that the co-insurers also will have to share the burden of responsibility of discharging the service tax obligations. It is time that clarity is provided on the applicability of service tax to co-insurers.

While the insurance industry will have to live with the levy of service tax for years to come, what they seek is only clarity on operating issues. Any levy of service tax tantamounts to an added cost to the insured and therefore the rate of service tax has to be kept within manageable limits and the lawmakers should desist from using the rates with the sole objective of raising revenues.

The issues raised above are only the tip of the iceberg and many more practical problems will surface as we go along. After opening up the insurance industry to private players, innovative products will also enter the market which will pose their own share of problems in interpreting and applying service tax provisions. Only time will tell whether the efforts taken produce the desired results in terms of getting resources with minimum pain.

The author is Vice President (Corporate Affairs), Sundaram Finance Ltd. The views expressed here are his own.

India to benefit most from $ 356 Billion offshoring

In a comprehensive survey of their moves offshore, the world's 100 largest financial-services companies indicated that they expect to transfer an estimated $ 356 billion of their operations and two million jobs offshore over the next five years in efforts to reduce their costs significantly.

The survey by Deloitte Research found that financial institutions expect to reduce costs by nearly $ 1.4 billion each by 2008 by sending work to low-cost centres like India from developed economies in North America, Europe and Asia.

Of the financial services firms transferring functions offshore, nearly half are targetting India, which has a huge market of IT professionals who earn much lower wages than elsewhere. Ireland and South Africa are also attractive offshore centres, with China, Malaysia and Australia growing in popularity.

Deloitte Research estimates that more than a million jobs or about half of the estimated relocations will move to the Indian Ocean rim over the next five years.

The survey shows that banks and insurance firms are transferring offshore such functions as application development, coding and programming, accounting and finance, operations, processing and administration, contact support and call-centre operations.

The survey, in which 27 of the world's largest institutions participated, offers a snapshot of what financial-services concerns are planning in their efforts to transform their operations by reducing their cost base and making their organisations more international.

Thirty per cent of the respondents currently have existing offshore operations and that is expected to climb to 75 per cent within two years, according to the survey. It suggests that the firms achieve 39 per cent cost savings from moving operations to low-cost centres proving that offshoring is gaining momentum at a rapid pace.

The study draws four principal conclusions:

One: the offshore trend is driving a radical shift in the structure of the global financial-services industry and this transformation is just beginning.

Two: financial institutions that can utilise their existing offshore facilities expect significant future savings because they leverage offshore scale and scope; the challenge is achieving economies of scale.

Three: firms aspiring to move offshore should move quickly to capture the benefits of doing so, but the challenge is building capabilities quickly and prudently.

Four: firms who don't move offshore risk being left behind because companies moving offshore estimate future cost savings at about 45 per cent.

50-year gilt for pension funds

The Government is considering the insurance industry's request for the issuance of a 50-year government paper to help the introduction of pension plans. Insurers are understood to have suggested that these 50-year papers be priced 200 basis points above the 20-year gilt.

The Government has already been issuing longer term papers of maturity up to 30 years and insurers want these instruments to be kept exclusively for them as this would help the pension industry to take off.

Today, pension plans offered by insurance companies do not guarantee the rate of return on the annuity product during the vesting stage since there is no instrument available in the market backing up such a guarantee and annuity providers have to rely on medium-term instruments rolled over where there is the risk of falling interest rates as has been happening in the recent past.

Punjab National Bank eyes life insurance

Punjab National Bank is reported to have plans to float a life insurance venture with Apollo Tyres, Vijaya Bank and Principal Financial Group (PFG) of the US.

The bank's Chairman, Mr. S. S. Kohli, announced that the bank has applied to the Reserve Bank of India (RBI) for clearance to enter insurance and that the bank plans to hold a 30 per cent stake in the venture.

Apollo Tyres is to take 39 per cent, Vijaya Bank five per cent and the US-based Principal Financial Group would pick up the remaining 26 per cent.

The bank has been interested in entering the insurance business and has attempted other tie-ups in the past including one with Hero Group and DCM Shriram.

PNB will also start distributing New India Assurance's general insurance products through its branches by taking up a corporate agency.

They WANT to buy insurance!

According to Horizons 2003, a survey on upmarket India commissioned by BBC World and conducted by research agency NFO MBL, buying life insurance was on top of the investment agenda for upmarket families, specially the women.

The study covered professionally qualified working adults between 25-54 years with monthly household incomes of over Rs. 8,000 in the top six metros.

While purchasing life insurance products was on top of the investment list, these people were not averse to taking risks on the stock markets. Among loans taken, housing loans were the highest at 41 per cent followed by car loans at 37 per cent.

Consumer durables like washing machines, cars and desktops were much sought after and about 60 per cent of the respondents took vacations in the country, with five per cent travelling abroad – mostly to Singapore and then to the US.

Chola Gen takes Mitsui as partner

The Murugappa group, sole promoters of Cholamandalam General Insurance Company, will get $ 7 million (about Rs. 33 crores) from Mitsui Sumitomo Insurance Company of Japan for a stake in the insurance venture which has been renamed Cholamandalam MS General Insurance Company Ltd.

Mitsui will take a 26 per cent stake by bringing in additional capital as IRDA regulations prohibit promoters of an insurance company selling their stake.

The company will now also focus on 'Japanese and Korean business' – for which a separate division has been set up – and expects to earn about Rs. 15 crores from this segment.

The Murugappa group has another insurance arm – Chola AXA Risk Services Ltd., and the foreign partner there, AXA of France, has the option of either continuing with the joint company or selling its stake to Mitsui.

Foreign brokers set up shop

Three foreign brokers, Aon, Marsh and Willis groups, have been licenced by the IRDA to carry on broking business in the Indian market after forming joint ventures with Indian business partners.

Willis Group Holdings Ltd. the global insurance broker has formed a joint venture with Bhaichand Amoluk Consultancy Services Pvt. Ltd. to provide insurance broking and risk management services in India.

The joint venture, called Willis BA India Private Limited has been given a composite insurance broking licence by the IRDA on April 1.

Aon Global Insurance Services and Marsh India Ltd. were licensed in March and will also be offering broking services in the country.

SBI Life to offer EDLI

SBI Life Insurance Company is planning to offer Employees Deposit Life Insurance (EDLI) schemes which has hitherto been the sole turf of the Life Insurance Corporation of India (LIC).

The size of the segment is estimated to be Rs. 3,000 crores and the Government and the Employees Provident Fund (EPF) Commissioner, it is reported, are likely to clear SBI Life to enter it shortly.

Insurance companies had been allowed to offer this scheme from 1972 and LIC, being the only company then, took it up on the condition that the latter's schemes had to offer better returns and that too without the one per cent subsidy provided by the Government.

According to officials from SBI Life, it will be a win-win situation for both the entities because under the arrangement, the Government will save on one per cent subsidy it pays under the scheme which is close to Rs. 30 crores a year and will allow SBI Life to tap a Rs. 3,000 crore niche market segment and allow it to increase its portfolio.

AFP Mulls Steps To Boost Financial Advisory Services

The Association Of Financial Planners (AFP) is seeking regulatory approval for the exemption of pre-licensing examinations from various regulatory bodies in India.

The association has already received approval from the IRDA on April 22 and is working on approvals from the capital market regulator, the Securities and Exchange Board of India (SEBI) and the Association of Mutual funds in India (AMFI) shortly.

Noel Maye, chief executive officer of the Financial Planning Standards Board has been reported saying that with a plethora of financial products being offered to investors, either in the developed markets or the emerging markets, an investor needs to chalk out a proper plan with regard to his investments, based on his risk appetite and a 'distinguished cadre of certified professionals, we call financial planners,' helps the common investor do just that, so that he can maximise his returns with minimal risks.

Ranjeet S Mudholkar, CEO, AFP is reported saying that they have approached the Government of India, IRDA, SEBI and AMFI and all of them had given the AFP in-principle approval for the exemption of pre-licensing examinations, subject to some modifications made to their course module.

The AFP was established in April 2001 through the contributions of financial services companies, and is dedicated to developing and promoting an industry and providing unbiased financial advice to the investor community.

The Charter Member list of AFP comprises Alliance Capital, American Express, Bajaj Capital, Cholamandalam Finance, Deutsche Bank, Franklin Templeton Investments, IDBI Principal, IL&FS AMC, Prudential ICICI Mutual Fund, SKP Securities Ltd and SUN F&C MF.

Only LIC will get pension scheme subsidy

The Government is reported to have turned down requests by private insurers for interest subsidy grants on pension schemes, only promising it to life insurance corporation's (LIC) 'Varistha Pension Bima Yojana' proposal which was announced in the Budget 2003 with an assured return of nine per cent.

The scheme envisages a monthly pension of between Rs. 250 and Rs. 2000 for senior citizens aged 55 and above, working out to a rate of return of nine per cent on the principal amount deposited.

The gap in earnings on that fund by the LIC and the promised nine per cent return was proposed to be subsidised by the Government.

Shortly after, private insurance players also wanted to be given the opportunity to avail of a subsidy and offer the pension scheme, but this has been turned down. The IRDA also wrote to the Government that any such subsidy extended to one player, namely the LIC, should be extended to all life insurance companies to ensure a level playing field.

Lloyd's returns to profits

The Lloyd's of London insurance market reported its financial results for 2002 with a profit of £ 834 million on a pro forma annually accounted basis and an initial projection of profit of £ 1,484 million on a three-year accounted basis for the 2002 underwriting year. The result is in line with expectations and marks a strong return to profitability for the market.

Lloyd's Chief Executive, Mr. Nick Prettejohn, said that these results demonstrated a very strong performance. It was the market's resilience and disciplined approach, at a time when the industry as a whole has faced many difficulties,that generated 2002's healthy result.

These figures compare very favourably when measured against the market's peer group.

Lloyd's combined ratio for 2002 was 98.6 per cent. This compares with an average of 105.1 per cent for European reinsurers, 121.3 per cent for US reinsurers and 108.3 per cent for US property and casualty insurers.

During 2002, the net resources of the Society and its members increased by 85 per cent to £ 7,509 million (from £ 4,052 million in 2001). Lloyd's central assets increased by 55 per cent to £ 563 million (from £ 363 million in 2001). Based on current expectations, the central assets are forecast to grow to approximately £ 800 million by the end of 2003.

Commenting on the prospects for the market in the immediate future, Mr. Prettejohn said, "The state of the capital markets and the continuing actions by many insurers to increase their reserves for past underwriting means that the Lloyd's market should enjoy positive trading conditions in the medium term."

Lloyd's is the world's leading insurance market with a capacity to accept insurance premiums of up to £ 14.4 billion. It is the world's second largest commercial insurer and third largest reinsurer.

In 2003, 71 syndicates are underwriting insurance at Lloyd's, covering all classes of business from more than 120 countries worldwide. Approximately five per cent of world reinsurance is placed at Lloyd's which also accounts for half of the London market's international insurance premiums.

AIG hurt by liability insurance charges

AIG, the world's largest insurer, which is itself facing mounting liabilities on its exposures to director's liability insurance, is faced with an almost 60 per cent rise in the cost of the premium it pays to protect its own board and executive officers. Its premiums have gone up from $ 1.8 million to $ 2.8 million.

Directors' and officers' insurance, known as D&O, has become far more expensive following the wave of corporate scandals, the huge increase in shareholder litigation against companies and the rising cost of individual pay-outs.

The rising cost of premiums is not all good news for insurers however. Many companies are suffering because they underpriced the policies in previous years.

AIG warned over a year ago, before the extent of the corporate scandals became clear, that the insurance industry was facing a bad run of D&O claims. Then, this February the company shocked investors with a $ 2.8 billion pre-tax charge, mostly to boost reserves for casualty claims and to account for D&O pay-outs.

AIG has already made significant changes in its communication strategy in response to changing governance expectations, holding its first earnings conference calls, making full-year profit forecasts for the first time and increasing the detail of its financial statements. It has now added a nominating and corporate governance committee of the board "to recommend individuals to the board of directors and to review on an ongoing basis the corporate governance principles and practices that should apply to AIG".

One million illegal drivers in the UK

It's so common here that we take it for granted. Drivers with fake licences and no licences even! But a recent survey has revealed that a million motorists take to the road every day in the UK with no driving licence, no road tax and no car insurance.

They are prepared to risk getting caught because they believe a fine will be cheaper than paying out every year for the proper documents.

Research by Auto Express magazine estimated that five per cent of drivers use their cars illegally and insurance experts reckon £ 30 of every UK policy pays for people who refuse to get cover against accidents.

Significantly a recent American study found that unlicensed drivers are five times more likely to be involved in fatal accidents.

Lloyd's, Swiss Re argue over terrorism bill

Lloyd's of London is squabbling with Swiss Reinsurance and five other international insurers about who should pick up part of the tab for the terrorist attacks in New York on September 11, 2001, and other disasters.

The London insurance market said it had opened arbitration proceedings against Swiss Re and the others, which jointly sold Lloyd's a policy that could protect it against as much as £ 500 million ($ 1.30 billion) in losses.

Lloyd's said it paid £ 78 million for the five-year policy, which expires at the end of this year. It is designed to cushion Lloyd's from losses on its central fund, a pool of money available to cover claims that can't be met by the market's "members" – corporations or individuals who pledge their wealth to back up policies sold by the 71 syndicates that sell insurance at Lloyd's.

The costs of paying claims from September 11 and other disasters have driven some members out of the Lloyd's market in recent years. Like other insurers, Lloyd's has been struggling to pay off old claims and rebuild reserves.

Lessons from HIH

Accountants and auditors should be subject to tougher rules so that investors can have confidence in their figures, according to the HIH Royal Commission report. Tougher rules are a part of a raft of reforms proposed by commissioner Neville Owen.

Justice Owen said if more stringent auditing rules were not put in place to guarantee professional independence then regulators should consider rotating auditors among companies.

Rotation of audit firms would result in accounting firms not having long-term audit relationships with a single company. In the present situation an audit firm can retain a client for many years, just as Arthur Andersen audited HIH in its various corporate forms since 1971.

Recommendations affecting the way accounting firms conduct audits include proposals to:

- Extend a ban on former audit partners from joining the board of a former client from two to four years.
- Extend to senior audit personnel the restrictions on joining the board or management of a former client.
- Ban non-audit partners from joining the board of a client company for two years after they leave the firm.
- Prohibit any more than one former partner of an audit firm from being a director on the board or taking a senior management position with a client.
- Call for a mandating of plain-English audit reports and the inclusion in annual reports of an auditable management discussion and analysis.
- Seek faster resolution of interpretations of accounting standards and disputes between auditors and management.

HIH shareholders go to court

More than 1,200 shareholders of Australia's collapsed HIH Insurance have started legal proceedings to recoup A$ 70 million in losses.

The Royal Commission's report into the insurer's demise was published in mid-April. The failure of the insurance company left debts of A$ 5.3 billion, and shareholders have launched an action to sue HIH's former directors, auditors and reinsurance firms. They claim they were misled about the value of the shares.

Tony McGrath, HIH's liquidator, has already initiated proceedings against the federal government, Arthur Andersen and David Slee, the insurer's actuary, over the collapse.

The government has also asked authorities to investigate the 56 possible breaches of the law by former HIH executives identified in the report.

The 1,500-page report by Justice Neville Owen found that bad management and a failure to provide properly for claims were responsible for HIH's collapse.

He said that Ray Williams, HIH's founder and former chief executive, might have provided false information, breached his duty of care as an officer of the company, and misused his position, while Rodney Adler, who sold FAI to HIH and became a board member at the parent company, might have obtained money by false or misleading statements.

A handful of other HIH executives, including Dominic Fodera, the former chief financial officer, should also be investigated for possible legal breaches, Justice Owen said.

HIH's collapse left tens of thousands of Australians without insurance cover, threw the exposed building industry in turmoil and severely rattled investor confidence.

A Policy of Protection

The IRDA has been receiving a number of letters from members of the public and also from clients of insurance companies regarding the protection of the policies under the current regulations. Often questions are also raised about the credibility of the insurance companies in the private sector as to whether they will continue to function in India in the future and also discharge their liabilities.

This Authority has been taking steps to indicate to the general public that no insurance company can carry on any business in India without being registered with the IRDA. The process of registration is a very long and strict one where the credibility of the applicants is assessed in regard to their ability to continue the business, their commitment to the Indian market and their financial strength. In addition, before a product is launched in the market by insurance companies, the proposal of the product along with all the related documents is to be filed with the Authority for a period of thirty days. The Authority makes sure from the proposal of the product filed with it that the product is suitable for the Indian market and fulfills all the requirements of the market.

In this regard, one of the queries raised by a Chartered Accountant of Delhi, Mr. Kamal K. Gupta, with the Authority and our reply issued to him are being published for general information.

N. Rangachary
Chairman

Dear Sir,

On behalf of my client Mr. Sanjeev Agarwal, MD, Moon Beverages Ltd, I have a few questions regarding the credibility of your company (MetLife India Insurance Company Limited) in the insurance industry. Please address the following questions to enhance my confidence in your company.

1. What steps have been taken by the IRDA to protect the investors?
2. What if the company winds up operations after a few years? Who would be responsible for my policy?
3. Does the LIC have a sovereign guarantee of the Government of India?
4. If my agent offers me a discount, can I accept it or is discounting illegal?

Looking forward to your response at the earliest.

Kamal K. Gupta
Chartered Accountant

Dear Shri Gupta,

Reg.: The Authenticity of M/s. MetLife India Insurance Co. Pvt. Ltd.

Your letter dated 7th April, 2003 to Mr. Biswajit Das Gupta, Sales Manager, M/s. MetLife India Insurance Co. Pvt. Ltd. regarding the authenticity of that Company has been forwarded to us by M/s. MetLife India Insurance Co. Pvt. Ltd.

As a Chartered Accountant I thought you would be fully conversant with the developments in the financial sector, more particularly the benefits that are available to the members of the public from the policies of the insurance companies both old and new. Since, your letter discloses that you require some basic information regarding the concept of protection of policyholders' rights, I refer you to the Protection of Policyholders' Rights Regulations that are formulated by this Authority. A copy of these regulations is enclosed for your perusal and I am sure that you will use the information contained therein to advise not only your client Mr. Sanjeev Agarwal, MD, Moon Beverages Ltd., but all of your clients, so that each one of your clients will be well informed about what insurance protection is. Now to your specific queries:-

1. What steps have been taken by the IRDA to protect the investors?

The IRDA (Protection of Policyholders' Interests) Regulations, 2002, deals with the vast area of rights of the investors starting with the right to obtain a copy of the proposal, the free look in period in respect of life policies, a copy of the concluded policy to be furnished to the client and also the obligations of the insurance companies regarding servicing and extending of the policy, payment of interest in case of delayed settlement of the policy claims, etc.

The regulations also prescribe a procedure for settlement of grievances including the appointment of the Insurance Ombudsman at specific centres in India. In addition to this, the IRDA Act empowers the Authority to look into the settlement of the grievances and, in cases where the policyholders approach the Authority directly, the Authority often intervenes with the insurers for the protection of their rights.

2. What if the company winds up operations after a few years? Who would be responsible for my policy?

The philosophy of insurance is the long-term commitment by the insurers to the policyholders, more particularly in case of life insurance business. The insurers can carry out insurance business in India only after being registered with the IRDA. Prior to grant of this registration, the Authority does an examination of the credibility, financial strength and commitment of the applicant to the Indian market. Only in suitable cases will the Authority grant registration to the applicant.

As a policy, the Authority looks into the business projections of an applicant for 10 years to ensure that the business plan to be carried out by the applicant would be on a sound basis and there would not be any attempt to under-cut the interests of or under-price a product of a competitor which will affect the strength and solvency of the insurer.

The solvency projection should be maintained on a current basis. In rare cases where life insurance businesses get into difficulties, the regulator has the power to approve another insurance company to take over the current liabilities and the policies of the company in difficulties.

3. Does LIC have a sovereign guarantee of the Government of India?

The Life Insurance Corporation of India Act has a provision of a guarantee of the Government of India with regard to the liabilities arising on policies issued by the LIC. This is an owner's guarantee (of the Government).

4. If my agent offers me a discount, can I accept it, or is discounting legal?

The agent is bound by law not to offer a rebate from out of the commission he gets. If he gives the discount to the customer from the commission that he receives from the Insurance Company, it will be an offence under the Insurance Act, 1938.

I hope by now you are conversant with the credibility of the insurance companies in the Indian market. You are now in a position to act as the representative of the IRDA to convey this information to your friends and clients.

Yours sincerely,
Sd/-
N. Rangachary
April 21, 2003

Mr. R. Bupathy, President, Institute of Chartered Accounts of India (ICAI), lights the lamp to mark the inauguration of the post qualification course on Diploma in Insurance and Risk Management at a function in Chennai on April 19. Also seen in the picture are (L to R) : Mr. P. A. Balasubramanian, Member (Actuary), IRDA, Mr. G. K. Raman, Chairman, Royal Sundaram Alliance Insurance Company Ltd., and Mr. V.C. James, Secretary, Southern India Regional Council, ICAI

Insurance for CAs

The Institute of Chartered Accounts of India (ICAI), has commenced a post qualification course on Diploma in Insurance and Risk Management for its members. The course, approved by the Department of Company Affairs and the IRDA, is the first effort by the ICAI to open up new professional avenues for its members in the field of Insurance.

Memorial Lecture

The Administrative Staff College of India (ASCI) conducted the annual K.L.N. Prasad Memorial Lecture at Hyderabad on April 23. Mr. N. Rangachary, Chairman, IRDA, spoke on ' Regulation of the Financial Sector – Freedom of the Regulator.' The lecture is conducted under an endowment by the K.L.N. Trust, in memory of Mr. K.L.N. Prasad an industrialist and Member of Parliament who was associated with banking and insurance institutions.

Mr. D. Seetaramiah of the K.L.N. Trust welcomes Mr. N. Rangachary, Chairman, IRDA, to deliver the K.L.N. Prasad Memorial Lecture.

Impartiality demands that a regulator should not have any direct or indirect vested interest in the business which it regulates, not hold a political position. Competence requires an exceptional technical and operational knowledge of the business

Such an individual could prove non-existent in a developing country. First, the pay scale is generally too low to attract and maintain qualified personnel. Thus, the chance of finding a competent regulator from the government is remote.

Secondly, in a fast-growing service sector, the persons who best understand the business are those involved in the business themselves.

In a situation where the processes of regulation and liberalisation convert an existing restrictive market to a more open one, as in most of the Asian countries, the choice of competent and technically efficient personnel to man regulatory bodies gets severely limited to the current crop of institutions in the public sector. It is therefore not surprising that half of the committee members of the many regulatory bodies are former employees of the State monopolies.

The presence of former operators on the regulatory board may render the impartiality of the regulatory body not only questionable but in many cases lead to a tunnel-vision often affecting the quality of the regulation. The lack of qualified and experienced personnel poses a serious problem for most countries.

N. Rangachary, Chairman, IRDA, in the K.L.N. Prasad Memorial Lecture.

Dear Editor

For surveyors

I want to convey to you and all your team members many congratulations for providing the Indian insurance sector a one of its kind journal, which covers all aspects of and topics in the sector.

The article 'Eleven Desired Habits of Highly Effective Surveyors' (**IRDA Journal**, March, 2003), was very informative and author had explained each and every point very nicely. I am sure every surveyor and adjuster must try his best to bring in practice all the eleven habits.

I hope that in near future we will find many more topics related to surveyors in the Journal, which will guide and enrich the surveyors' community in India.

I am happy that IRDA is trying hard to develop the skills of the surveyors' community in India. I hope that IRDA will also try to look at and solve the problems being faced by the surveyors working in small cities and towns.

Yogendra Prakash Gilra
SLA-7776
Hony. Secretary – IISA Garhwal Unit
Badrinath Marg, Kotdwara – 246149, Uttranchal

Waive it!

This is a request to the Chairman, IRDA. Sir, we suggest that the valid Associate diploma holders of Insurance Institute of India should be exempt from undergoing the 50 hours training required as a pre-requisite to become an insurance agent. We request you to consider the above suggestion in the larger interest of entry of the professionally qualified agency force for developing the insurance awareness in our country.

Dr. L.P. Gupta
120, Vaishnav Building,
Surendra Place,
Bhopal 462 026

Useful things

First of all I am very thankful to you for enrolling my name in your mailing list to send **IRDA Journal.**

I read all your issues thoroughly. The information given in the magazine is not available in any other magazines. I am very impressed with the article on 'How the Ombudsman works' (**IRDA Journal,** April, 2003). The presentation of the information is very impressive.

I suggest one more section you could start and that is Questions & Answers.

You could also add information about new insurance policies introduced by the LIC, GIC or private insurance companies.

K.R. Bhatt
LIC-Agent, Mahuva Branch, Gujarat.

Dear Mr. Bhatt,
Your suggestion for a section on Questions and Answers is timed perfectly! We have started just such a section (see page 46, this issue, section called Your Questions). Please feel free to send us any doubts you would like to see clarified and we will do our best.

Some thoughts

Here are a couple of reviews on articles that caught my eye. It's only a reflection of how I felt about it.

Mr. R.C. Sharma's article 'Ageing Society – Whose Baby?' (**IRDA Journal**, April, 2003) addresses the very problem of our nuclear family systems which are on the rise. With globalisation, brain drain and a fast pace of life the bread-winner is constantly on the move to increase his personal finances as also that of his family.

Health and family interaction are a myth of the past. It is only when he retires that he discovers the void of lost communication and the disastrous state of physical health that he has endowed upon himself. He finds that he laboured to earn for severing the bonds of close living and is now with his better half whom he neglected in this quest. He is left with a situation where he discovers that he needs to fill the void of communication with his own partner as also redo his finances to support their unforetold future.

Yes indeed! as rightly pointed out by the article - an insurance scheme that will help him plan to lead a comfortable financial life of not too much thrift nor overindulgence could certainly assist.

Is it the guideline of a training programme or the trainee himself that determines quality of the output?

The article on training by Mr. Vijay Vora describes all sorts of situations and conditions that can be adopted to enhance training programmes. But it fails to address the role of the trainee. Every training programme is finally the outcome of a trainee who graduated from a similar protocol that he underwent.

What would be of interest is to understand that the present generation with the mass influx of foreign collaboration in the insurance industry envisions quick monetary gains for minimal effort or strife as the prime goal of work ethics. The torch bearing quality is of question as values have deteriorated drastically. It is easy to put the blame on the influx of foreign investors and state their culture has trickled in. Hey! But they were success stories in their countries so what's failing at your end? Think about it!

Is it only trainers or training programmes or the mettle of the trainees? A thought to meditate on?

Anjali Gharpure
Librarian,
The Actuarial Society of India,
9, Jeevan Udyog, 278, D.N. Road,
Mumbai 400001

The U.S. litigation system, if left unchecked, will destroy the American spirit of enterprise and drain the U.S. economy... (it) has spawned an American pastime: going to court to sue other people, or companies, or organisations, or the Government. And as more and more people have gone to court, not only has the cost of doing so risen, but so too has the cost of insuring oneself or one's company against litigation. To a foreigner like me, the drain that this system has on the U.S. economy is unbelievable.

Lloyd's of London Chairman, Lord Peter Levene,
in a speech in Chicago.

There is a risk that . . . senior audit personnel may become too sympathetic to a client's interests, particularly if their long-term career aspirations become linked to their continued material role in the conduct of the audit.

Justice Neville Owen, Royal Commissioner inquiring into the collapse of HIH Insurance, Australia, in his report.

The wealth of a defendant cannot justify an otherwise unconstitutional punitive damages award. Punitive damages must be related to the actual conduct at issue... (and) should conform to the size of whatever civil penalty can be imposed by a state agency for similar conduct. (The 145-to-1 ratio) is neither reasonable nor proportionate to the wrong committed ...(it is) an irrational and arbitrary deprivation of the property of the defendant.

Justice Anthony Kennedy of the US Supreme Court, while ruling against a $ 145 million judgement against State Farm Insurance Company in an auto accident case that produced only $ 1 million in compensatory damages.

If the courts find people guilty, yes, it would be appropriate for them to go to jail.

Mr. Peter Costello, Federal Treasurer, Australia, on the charges made by the Royal Commission's report on the collapse of HIH Insurance.

We do not need a VRS. We need people to manage our growing business, we need people to take care of our 10 crore policyholders. Every year, we add over one crore policies to the existing base and the organisation has to service them properly. (As for agents) I think we should stop here (at 9.5 lakh) and look for quality.

Mr. S. B. Mathur, Chairman, LIC,
on personnel needs of his company.

We are in one of the worst bear markets of the last century; interest rates are low and will continue to remain low... for these reasons, combined ratios are improving and the insurance industry is extremely focused on achieving underwriting profit. We expect the hardening market in the P&C sector to continue for some time.

Mr. John Coomber, Chief Executive Officer, Swiss Re

RNI No: APBIL/2002/9589

Events

May 5-9, 2003
Venue: Beirut
Financial Stability Forum's Special Seminar with the World Bank
Topic: Anti-Money Laundering

May 9-10, 2003
Venue: Delhi
IRDA & Indian International Law Forum: Conference on Insurance

May 19-23, 2003
Venue: Vienna
Financial Stability Forum: Selected IAIS Insurance Core Principles

May 26-30, 2003
Venue: Vienna
Financial Stability Forum: Core Supervisory Issues

May 26-30, 2003
Venue: Beatenberg
Financial Stability Forum's Focused Seminar
Topic: Risk Management

June 2-3, 2003
Venue: World Bank headquarters, Washington DC
Financing the Risks of Natural Disasters: A New Perspective on Country Risk Management

June 8-10, 2003
Venue: Bangkok, Thailand
11th Annual LOMA/LIMRA Strategic Issues Conference

June 19-20, 2003
Venue: Mumbai, India
4th Conference on Bancassurance & Alternative Distribution Channels
Choosing the Right Bancassurance Business Model

June 23-25, 2003
Venue: Bangalore
5th Asia Pacific Conference & Exhibition on IT & e-Applications in Insurance
IT & e-Applications to Boost Business & Efficiency – Getting Beyond the Hype & Mantras to Exploit the Right Technologies Best Suited to your Business

July 8-9, 2003
Venue: Taiwan
2nd Conference on Catastrophes Insurance in Asia
Seeking Real Solutions to CAT Exposures in Asia

July 13-16, 2003,
Venue: New York
39th Annual International Insurance Society Conference

July 24-26, 2003
Venue: Singapore
Singapore Insurance Institute Conference – Towards Professional Excellence