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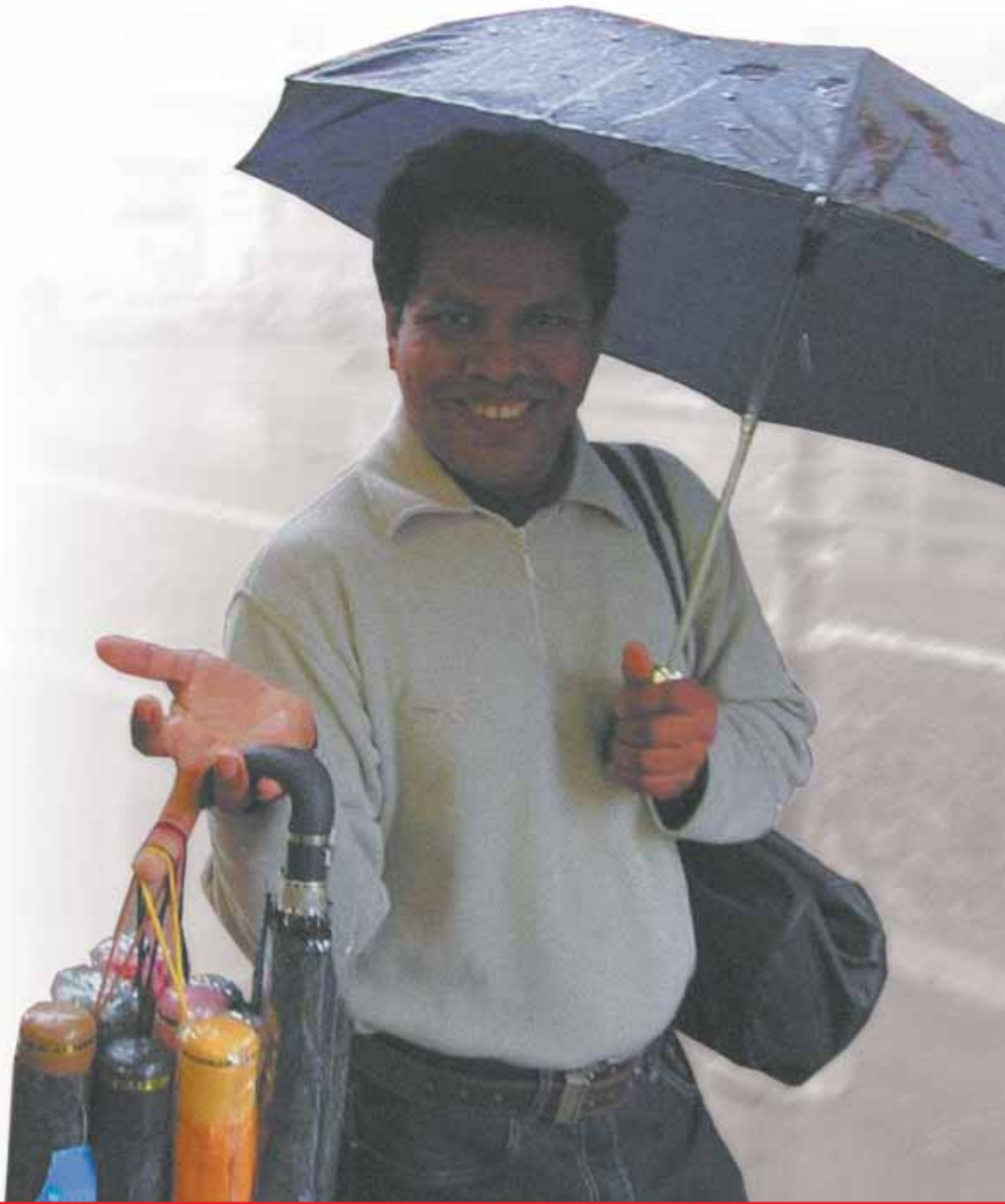

बीमा विनियामक और विकास प्राधिकरण

Journal

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From the Publisher

Insurance is about evaluating risk and devising appropriate mechanisms to cover that risk. As with any industry, the insurance industry faces risks of its own. Some similar to others and many, quite unique. Risk management within the insurance industry is what we look at in this issue of **IRDA Journal**.

Transparency and adherence to sound principles of governance are key to risk management. The Authority is in the process of framing corporate governance norms for the industry and, simultaneously, is encouraging the different stakeholders in the industry – like life and non-life companies, brokers, surveyors – to create or activate forums to function as self regulatory organisations. The move from central regulation to self regulation is a reflection of a global trend where good market conduct is ensured by the players themselves through market discipline and supervision.

Collective efforts at regulation are more conducive to setting high standards and maintaining them. There is sound reasoning behind this. It is that all players in the financial sector are interlinked not only by transactions but by perception also. A crisis in one company leads to serious apprehensions among the customers of all companies triggering a cascade of knee jerk reactions. Industry members realise that their strength depends on the weakest link and the collective wisdom of the industry members would be to guard against that link being so weak that it will snap and plunge all of them into crisis.

The next issue will explore an area where the Authority wishes to see rapid development. Health insurance is linked with reforms of the healthcare provider system. Given that reform in that area is not in the hands of the insurance system, we would like to see what can be done without waiting for major reforms in the providers' domain. The focus of the development has to be health insurance for that section of the population who can afford to pay the premium but cannot meet the cost of treatment. There are, however, sections of the population who cannot meet even the modest cost of premium. What are the interventions needed to help them? How do we devise an insurance cover that does not result in pushing the cost of providing health services upwards? These are issues of major concern and we look forward to innovative ideas to address these concerns.

C.S.RAO

Inside

ISSUE FOCUS

Self Interest

How physicians heal themselves is the topic for this month's issue of **IRDA Journal**. Through the eyes of a cross section we see how the industry that specialises in assessing and monetising risk manages its own risks. We have writers like Mr. G. V. Rao with whom regular readers are familiar, Mr. John Thorpe of Aon Insurance and Dr. Sadhak, Executive Director, LIC giving us their inputs on the topic.

The way the Regulator manages risk, perhaps, is by laying down regulations and reporting standards and monitoring them scrupulously. And the reporting required of the insurance industry is a critical input in carrying out this task. There is exhaustive input from Mr. Shriram Mulgund, an Indian actuary working in Canada who details and analyses the financial reporting standards required of Canadian life insurers and compares them to those for Indian life insurers.

The IRDA has also put out a concept paper on Microinsurance which is a formalisation of the social sector coverage that the regulator would like to enable and ensure. Being one of the key expectations of the society out of liberalisation of the insurance market, developing microinsurance and along healthy lines too is IRDA's concern and it plans to bring out suitable regulations towards this end. What you will read in this issue is the draft of that regulation for comment before finalisation.

We resume the Keeping Count column of Mr. P. S. Prabhakar after a break that was forced by special articles and additional statistics in the recent issues. We also bring you the final part of Mr. M. Arunachalam's series on Technology and the Indian insurer, this one focussing exclusively on the status of IT in Indian insurance companies. His recurrent theme of enterprise wide connectivity and data mining and warehousing as essential and critical to the insurance business is reiterated.

The next issue is on health insurance and is timed to coincide with a conference on health insurance that IRDA is holding in October in Hyderabad. We would like to present ways to take health insurance to the huge and definitely interested population overcoming the disadvantages of a heterogenous healthcare industry with its price disparities, geographical inequities in availability and price opaqueness.

This is one customer lead product and insurance companies must be thinking of ways to manage the downside and exploit the market. If you wish to share your ideas with our readers write in to us quickly!

K. Nitya Kalyani

To Health Insurance!

K. Subrahmanyam

Can life insurance companies transact health insurance business? This is the question that is asked of us in the IRDA in various forums.

The answer to that is Yes. Life insurers registered with IRDA can transact health insurance business. Not only as riders and not only benefit policies but also standalone, indemnity policies. In fact, Tata AIG Life Insurance Company is already transacting health insurance business selling standalone health insurance contracts.

Some life insurers are skeptical that by law they cannot issue health insurance contracts. Some do not have capacity or the required infrastructure to handle such contracts - particularly when it comes to claims settlement. In this article, we describe how a life insurer can legally transact health insurance business.

Definition of health insurance business

Health insurance business has been defined in the IRDA's Regulations on Registration of Indian Insurance Companies, which covers indemnity-type benefits as well as assured benefits. The definition is:

"health insurance business" or "health cover means the effecting of contracts which provide sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out patient, on an indemnity, reimbursement, service, prepaid, hospital or other plans basis, including assured benefits and long term care;

It is obvious from the definition that health insurance contracts could be short term or long term, and could be of the reimbursement type or the fixed benefit amount variety, or both. The definition is highly flexible and broad since the objective was to serve the needs of the insuring public.

Who can sell health insurance contracts?

The Insurance Act, 1938 allows both life insurers and general insurers to sell health insurance contracts to individuals or groups, and says that the

> The Insurance Act, 1938 allows both life insurers and general insurers to sell health insurance contracts to individuals or groups.

Authority should give preference to those insurers who plan to have a focus on health insurance at the time of granting of certificate of registration. Section 3 (2AA) of the Insurance Act, 1938 spells out clearly who can offer health insurance contracts and to whom, and the meaning of health insurance contracts.

Section 3 deals with the registration of insurers. Sub-section 2AA is reproduced below:-

2AA) The Authority shall give preference to register the applicant and grant him a certificate of registration if such applicant agrees, in the form and manner as may be specified by the regulations made by the Authority, to carry on the life insurance business or general insurance business for providing health cover to individuals or group of individuals.

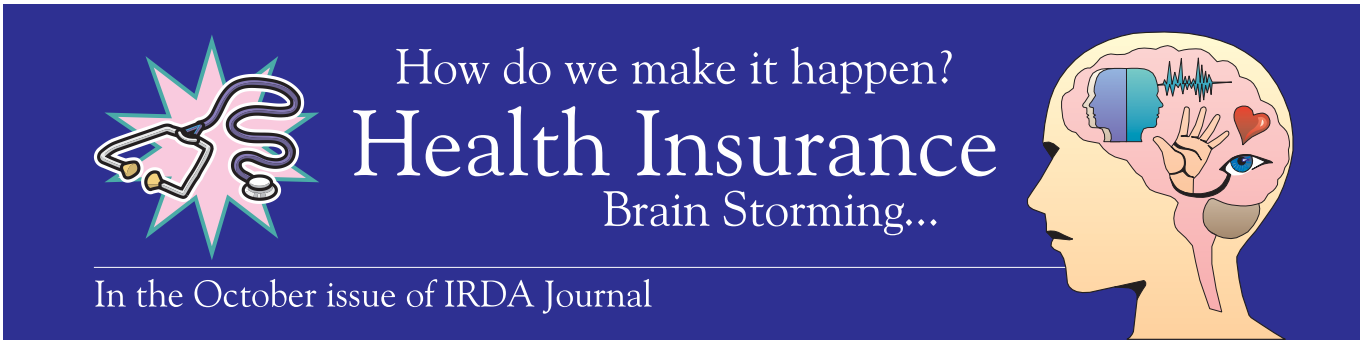
An applicant who wishes to be registered as an insurer shall either do life insurance business or general insurance business but not both. In industry parlance, no company can be a composite insurer. However, if the applicant chooses life insurance business, he can transact health insurance business. If the applicant chooses to become a general insurer too, he can transact health insurance business!

Why are insurers, particularly life insurers, not actively selling health insurance contracts?

Many life insurers are offering health insurance riders instead of standalone products, which they probably evaluate as being easier. For standalone health insurance contracts, one should have, among other things, expertise in health product design and pricing, definitions and claim settlement procedures. Life insurers are stopping with selling riders and assured benefits without thinking of diversifying their activities.

They need to diversify their activities to enter this area too, particularly since services in corporate hospitals are becoming better and TPAs (Third Party Administrators) are in place throughout India. Managed healthcare too is possible in India.

The author is Executive Director (Actuary) IRDA.



New Guidelines for Agents' Training Institutes

IRDA has released draft guidelines for insurance agents' training institutes accredited by it, including in house training institutes. The objective is to streamline the functioning of these institutes. The following guidelines were placed on the website of the Authority and comments were invited from the industry before finalising the guidelines.

Draft guidelines

These instructions/guidelines are applicable to all the training institutes including in-house training institutes of the insurers. These guidelines will be effective ----------, 2004. Any violation, non-adherence and breach of these instructions shall be treated as violation of provisions of IRDA Act, Insurance Act and regulations made thereunder requiring practical training for the grant of licence to an insurance agent and renewal thereof and met with penal provisions including fine, suspension, and cancellation of the approval granted by the Authority from time to time.

1. The applicant shall have to undergo at least 100 hours of practical training in life or general insurance business which may be spread over three to four weeks, where such applicant is seeking licence for the first time to act as an insurance agent. The approved training institutes will cover the syllabus already prescribed by the Authority during this period. In case of 50 hours of training, the duration will be half as mentioned above.
2. The training duration should be minimum 18 working days excluding Sundays and holidays with six hours per day excluding lunch and tea break applicable for full time batches. For parttime batches the training can be imparted three hours daily in the evening excluding tea break and the minimum duration of the training will be 34 working days excluding Sundays and holidays.
3. No product training/market survey/revision examination should be included into this 100 hours training. The product training, if any, to be given by the insurance company should be over and above the minimum training hours prescribed by the Authority.
4. The attendance record of the trainees should be maintained at the institute for necessary inspection at any given point of time. The candidates should sign the attendance register in his/her own hand-writing. It will be the duty of the person in charge of the institute to mark absent, preferably with red-ink. No relaxation in attendance is permitted. The attendance will be countersigned by the faculty or in charge of the training centre.
5. In case of short-fall of attendance, extra class may be permitted but the extra hours may be specified separately with proper attendance and details of faculty.
6. Every Institute should have at least one qualified permanent faculty who is at least an Associate or Fellow from the Insurance Institute of India for each stream. Those not fulfilling this requirement may be required to obtain the above qualification within two years.
7. The attendance register of the faculty members should be maintained at the training institutes. The faculty should sign the attendance register in his/her own hand-writing daily. It will be the duty of the person in charge of the institute to mark absent preferably with red-ink.
8. The record of the payment made to faculty should be maintained at the training institute i.e. batch-wise payment details should be maintained. In case the employment of the faculty is full time, record of monthly wages/payment should be maintained.
9. The faculty should provide details of the other institutes with whom they have been empanelled as part-time/guest faculty.
10. The sponsorship letter must be available with the training institute at the time of commencement of training session and thereafter kept for the record and inspection purposes.
11. Register should be maintained at the training institute giving details of batches completed, strength of the each batch, number of candidates decertified, name of the sponsored insurer and details of faculty who imparted the training with dates. The record of results of the examination whether passed/failed recorded in the same register giving details of date of examination and centre.
12. The seating capacity of each class-room should not exceed 40.
13. The fresh accreditation will be given on need basis after assessing the needs of the particular city/town.
14. The initial approval will be for a period of two years and consideration of further renewal up to two years would depend on the satisfactory compliance of requirements of accreditation.
15. The insurance companies would regularly send their officials to the oversee the proper conduct of the training at the institutes and would not sponsor candidates to those institutes that are not maintaining the required standards of and facilities for the training.
16. The training institute must display the certificate of accreditation to impart training issued by the Authority at the training institute.
17. The institute should not allow a franchisee to conduct courses on its behalf even if the faculty is that of the institute. The institute should conduct the training on its own or hired premises with proper infrastructure.
18. No marketing fee/consultancy fee payment is permitted for getting the training batches.
19. Henceforth, no temporary accreditation will be given by the Authority. The existing institutes who have been granted temporary accreditation shall cease to operate within one month from the date of issue of these guidelines or the actual date of expiry whichever is earlier.
20. It will be the responsibility of the insurance company to check the status of the institute before sponsoring any candidates for training. If name of the training institute is not displayed on IRDA web-site, no insurer should sponsor the candidate for training to such an institute.
21. In case of mofussil areas or the cities where there are no accredited institutes and an insurance company intends to appoint agents, it will be the responsibility of the insurance company to conduct training and comply with the requirements strictly.
22. The institutes must keep with them one set of records of the training at the place where the training is being imparted.
23. No accreditation will be given to the institutes that are imparting training in the hotels. Fresh accreditation/renewal, if any, will be granted by the Authority only to Institutes who are maintaining good infrastructure and complying with all other requirements specified in the application form for licence/renewal of the criteria of obtaining marks which is placed on the web-site of the Authority already prescribed by the Authority in this behalf.
24. The institute should confine its activities only to the place/city for which it has been given the approval. No training outside the said place/city is permitted. The premises approved for the training shall not be used for any other purposes and no sharing arrangements in the said premises shall be permitted for other training or other institutes or organisations.
25. The institutes that have not conducted any training during the last financial year will not be considered for renewal.
26. (i) The existing institutes may convey their willingness to abide by these instructions on a simple form for each centre separately. The information may include: Name & Address of the institute, Date of accreditation of the institute, Expiry date of validity of the accreditation, Whether accreditation granted for Life/General or both, Name of the person in charge of the institute.

    (ii) The above information must reach the Authority within 30 days from the date of issuance of these guidelines. The consolidated list of approved training institutes will then be placed and updated from time to time on our web-site so that Insurance Companies can approach them for conduct of training.
27. Prior approval of the Authority must be obtained if the training institute intends to change any of the particulars, details or provisions already approved by the Authority. All such changes would be simultaneously incorporated on the IRDA web site.

BROKER SUSPENSION REVOKED

Following compliance with the regulations and an undertaking to ensure strict compliance in future, IRDA has revoked the suspension order on the broking licence of Mass Insurance Brokers Pvt. Ltd. On June 8 this year, the broker's licence was suspended for violating Regulation 26 of IRDA (Insurance Brokers) Regulations, 2002.

IRDA CAUTIONS BROKING COMPANIES

IRDA Member (Non-Life), Mr. Mathew Verghese, has said in a circular to insurance broking companies expressing concern about information received by the Authority about Principal Officers of licensed insurance broking companies being engaged in other activities.

"Instances have also come to notice where Principal Officer(s) have left the services of the broking companies and the same was not brought to the notice of the Authority immediately but after a lapse of considerable time. In some cases, the Principal Officer was deputed to look after other assignments in the group companies while working as the Principal Officer. It has also come to Authority's notice that broking companies have appointed personnel from other broking companies without the incumbent Principal Officer resigning from his earlier position. In some cases, the broking companies fail to notify the Authority about the change in position of Principal Officer in their respective companies with the result that old names continue to appear on the IRDA Website," he said. The circular emphasised that the IRDA (Insurance Brokers) Regulations, 2002 envisage the post of Principal Officer as a full time post and not on part time basis and with considerable amount of responsibility attached to it.

The Principal Officer is responsible for conducting the affairs of the broking company in a professional manner and as per the rules and regulations laid down / prescribed by the Authority. He is the interface between the customers and the insurers. He also acts as a link between the Regulator and the broking company and is not permitted to look after any other assignment or position so long as he is the Principal Officer of a broking company, even for a temporary period.

Any change in position of the Principal Officer of a broking company should be brought to the notice of the Authority without loss of time and the position of Principal Officer of an insurance broking company cannot be kept vacant. The broking company should ensure a substitute, who fulfils all the eligibility requirements i.e. educational, training requirements, not suffering from any of the disqualifications under section 42 D of Insurance Act, 1938, etc., in place before it relieves the current Principal Officer, the circular said.

Towards Microinsurance

Microinsurance is the protection of assets and lives of those who belong to the economically weaker sections of the society. They include micro-entrepreneurs, small farmers, landless labourers and low income men and women through formal, semiformal and informal institutions.

The Authority has been, for some time, considering the need for having a separate regulation on microinsurance. It has set out the objectives and salient features of the proposed microinsurance regulations in a paper extracted below, and invites comments on it for finalisation and notification of the regulations.

Please send your comments to Insurance Regulatory And Development Authority, Parishrama Bhawan, Basheerbagh, Hyderabad 500004 in a sealed envelope superscribed "Micro-insurance" or by E Mail to microinsurance@irdaonline.org before September 15, 2004. The document is also on the Authority's website at www.irdaindia.org (click on "What's New".)

Background

Microinsurance products are often bundled with micro-savings and micro-credit, thereby allocating scarce resources to micro-investments with the highest marginal rates of return. Microinsurance is the most underdeveloped part of microfinance. Yet various schemes exist that are viable, benefiting both the institutions and their clients. Such schemes have generally served two major purposes: (i) they have contributed to loan security; and (ii) they have served as instruments of resource mobilisation. The greatest challenge for microinsurance lies in the combination of viability and sustain ability with outreach.

Although introduction of sound practices such as appropriate policy sizes and timely payment of instalments of premium or positive incentives to renew on time in order to avoid policy lapses can be feasible, the ultimate effectiveness of interventions focusing on institutional transformation and sound insurance practices will vary considerably, depending on the appropriateness of the regulatory environment.

Development goal

To enable microinsurance to be an integral part of a country's wider insurance system, it is important for every insurer to adjust its costs of serving marginal clients in remote areas, collecting premiums and instalments, and offering doorstep services.

Today we have a variety of microfinance institutions with national and local outreach. Many of them have already become corporate agents or have entered into referral arrangements with insurers. However, semiformal institutions including savings and credit cooperatives, NGOs and self-help groups which have immense potential in carrying the message of insurance as also solicit insurance business are yet to be utilized in a manner where their true potential can be harnessed to increase the insurance penetration levels. This is due to restrictions in the existing agency regulations in terms of minimum eligibility norms in order to become an agent.

Depending on the existence and vigour of such institutions, the following alternatives have emerged, for offering strategic entry points for microinsurance development:

i. Adapting formal insurance arrangements to the needs of the micro-economy.

ii. Upgrading non-formal (comprising semiformal and informal) insurance arrangements with insurance companies.

iii. Linking formal and non formal insurance institutions with banks and self-help groups.

iv. Establishing new local institutions providing microinsurance services.

The first three strategies may be inter-connected:

i. adapting insurance companies to the requirements of the micro-economy is a first step; then

ii. linking them as wholesale institutions to self-help groups as retailers; and finally,

iii. upgrading self-help groups e.g. to the level of financial cooperatives or village banks.

If insurers are to serve customers who differ widely in terms of service costs and risks, the only viable inducement for them is an adequate margin, lest they exclude small farmers, - micro-entrepreneurs and people in remote areas. Only sound social insurance, which combines a social mandate with profit-making, has a chance of sustainability.

Institutional adaptation

The experience so far has been that formal financial institutions serve but a fraction of the population, which typically lies within the upper quartile of the social hierarchy. Through adaptation to the microfinance market requirements, they may gradually expand into the second-highest quartile and into segments of the lower quartiles. Within the foreseeable future they will normally not be able to fully serve that market.

Non formal finance mostly rests on local institutions which are directly accessible to all segments of the population. Self-Help Groups (SHGs) are member-owned and member-controlled local institutions. They may either be financial groups, with financial intermediation as their primary purpose; or non financial groups, with financial intermediation as a secondary purpose, such as vendors' associations, family planning groups and numerous other types of voluntary associations.

The functions that need to be focused must include: providing guidance to members, collecting premium installments from members, insurance services to members, communication and exchange of experience, providing linkages with banks, NGOs or donors, supporting the proposals of individual members to insurance companies through recommendations.

Linkage to Insurers

On a modest scale, various forms of life and health insurance have been successfully practiced by different institutions in different countries, particularly as part of loan protection schemes. Micro-insurance procedures and services should be set by insurers rather than the regulator. Appropriate procedures and services should be applied to attain (1) sound financial management, (2) convenient and safe savings premium collection and deposit facilities, (3) appropriate claim appraisal and processing procedures, (4) adequate risk management, (5) timely collection of premium installments, (6) monitoring and (7) effective information gathering, all of which may include cooperation between different formal and non-formal intermediaries in fields where each is most effective.

Proposed Microinsurance regulations

In order to introduce the concept micro-insurance it is necessary to draft suitable bring in suitable regulations to enable insurers to design and distribute and service micro-insurance products and discharge their obligations to the rural and social sectors as per provisions of the Insurance Act, 1938.

1. It is proposed that an insurer transacting life insurance business shall be permitted to provide life micro-insurance products as well as general micro-insurance products provided it ties up with an insurer transacting general insurance business for the general micro-insurance products, and vice versa.

2. In addition to an insurance agent or corporate agent or insurance broker who are authorized to solicit and procure insurance business, including micro-insurance business with an insurer in accordance with the provisions of the Insurance Act, 1938 and the regulations made there under it is also proposed to introduce the concepts of "micro-insurance product" and "micro-insurance agent".

Micro-insurance product

3. A "life micro-insurance product" means any term insurance contract with or without return of premium, any endowment insurance contract or health insurance contract, with or without an accident benefit rider, either on individual or group basis, as per terms stated in the Table A below, filed with the Authority:

NOTE: The present average sum insured is around Rs. 5,000. This is highly inadequate to provide any tangible relief even to a individual below the poverty line. Therefore, it is suggested that the minimum amount of cover of Rs. 10,000 appears more realistic.

4. A "general micro-insurance product" means any health insurance contract, any contract covering the belongings such as hut, livestock, any personal accident contract, or tools or instruments, either on individual or group basis, as per terms stated in the Table B below, filed with the Authority:

Distribution of microinsurance products

5. The micro-insurance products may be distributed by individual insurance agents or corporate insurance agents or insurance brokers or micro-insurance agents.

Micro-insurance agent

6. A "micro-insurance agent" shall be a Non Government Organisation (NGO) or a Self Help Group (SHG).

Explanation: For the purposes of this regulation:

(i) a Non Government Organisation (NGO) shall be a registered non-profit organization under the Society's Act, 1968 with a proven track record of working with marginalised groups with clearly stated aims and objectives, transparency, and accountability outlined in its memorandum, rules and regulations and demonstrates involvement of committed people.

(ii) Self Help Group (SHG) may be an informal group or registered under Societies Act, State Co-operative Act or as a partnership

Table A

Type of Cover	Minimum Amount of Cover	Maximum Amount of Cover	Term of Cover Min.	Term of Cover Max.	Minimum Age at entry	Maximum Age at entry
Term Insurance with or without return of premium	Rs. 10,000	Rs. 50,000	5 years	7 years	18	60
Endowment Insurance	Rs. 10,000	Rs. 50,000	5 years	7 years	18	60
Health Insurance Contract	Rs. 10,000	Rs. 15,000	1 year	7 year	18	60
Accident Benefit as rider	Rs. 10,000	Rs. 50,000	1 year	5 years	18	60

firm, consisting of 10 to 20 with a proven track record of working with marginalised groups with clearly stated aims and objectives, transparency, and accountability outlined in its memorandum, rules and regulations and demonstrates involvement of committed people.

(iii) The minimum number of members comprising a group should be atleast ten for insurance of individuals, and atleast fifty for group insurance.

Scope and functions

7. A micro-insurance agent shall be appointed by an insurer by a deed of agreement or memorandum of understanding which should clearly specify the terms and conditions, duties and responsibilities of both the micro-insurance agent and the insurer, and he shall abide by the following:-

a. He shall work either for one life insurer or for one general insurer or for one life insurer and one general insurer;

b. He shall be specifically authorized to perform one or more of the following functions:—

i. Maintaining a register of all members and their dependants covered under the insurance scheme alongwith details of name, age, address, nominees and thumb impression/ signature;

ii. collection of proposal forms;

iii. collection of self declaration from the member that he is in good health;

iv. collection of monies for issuance of contract or remittance of premium;

v. distribution of policy documents;

vi. assistance in the settlement of claims;

vii. nomination; and

viii. any policy administration service.

c. The micro-insurance agent or the insurance company shall have the option to terminate the agreement/MoU after giving a notice of three months.

d. All such agreements/ MoU must have the prior approval of the Head office of the insurance company.

Remuneration/Commission

e. He shall be entitled to receive a fee from the insurer to cover for all services rendered, and which shall not exceed:

i. Twenty per cent of the premium in case of life insurance contracts; and

ii. Seven and half per cent of the premium in case of general insurance contracts.

In case of termination of agreement no future commission/ remuneration shall be payable.

Employment of specified persons

f. He may also employ specified persons with the prior approval of the insurer for the purpose of discharging all or any of the activities mentioned in (b) above. However, for the purpose of this regulation no corporate agent or individual agent licenced by the Authority shall be prohibited to employ any specified person for the purpose of soliciting and servicing of micro-insurance product.

Code of Conduct

g. The micro-insurance agent and every specified person employed by him shall abide by the code of conduct as mentioned in IRDA (Licensing of Insurance Agents) Regulations, 2000 and the relevant provisions of IRDA (Insurance Advertisements and Disclosures) Regulations, 2000. It shall be the responsibility of the insurance company to ensure compliance of the code of conduct, advertisements and disclosure norms.

Table B

Type of Cover	Minimum Amount of Cover	Maximum Amount of Cover	Term of Cover Min.	Term of Cover Max.	Minimum Age at entry	Maximum Age at entry
Hut or livestock or Tools or implements or other assets—against all perils	Rs. 10,000	Rs. 20,000	1 year	1 year	18	70
Health Insurance Contract	Rs. 10,000	Rs. 15,000	1 year	1 year	18	60
Personal Accident	Rs. 10,000	Rs. 50,000	1 year	1 year	18	60

Sanctions/ Penalty

h. Any violation of the code of conduct shall lead to termination of the agreement/ MOU with the insurer forthwith and shall attract the penal provisions as normally applicable to an insurance agent

Duties and responsibilities of the insurer

product design and development

8. Every insurer shall be subject to the "file and use" procedure with respect to filing of micro-insurance products with the Authority.

9. Every insurer shall issue insurance contracts to the individual micro-insurance policyholders in the local language which is simple and easily understood by the policyholders.

10. Every insurer shall issue insurance contracts to the group micro-insurance policyholder in the form of a schedule showing the details of individuals covered under the group, and also issue a separate certificate to each individual evidencing proof of insurance, containing details of validity period of cover, name of the nominee and address of the underwriting office.

Underwriting

11. No insurer shall be allowed to authorize any micro-insurance agent or any other outsider to underwrite any insurance proposal for the purpose of granting insurance cover.

Capacity building

12. It shall be the responsibility of every insurer to impart atleast 25 hours of training at its expense through its designated officer in the local vernacular to all micro-insurance agents and their specified persons in the areas of insurance selling, policyholder servicing and claims administration.

Remuneration/commission

13. No insurer shall pay or contract to pay any further amounts by way of fee or remuneration or compensation in any form other than what has been specified;

Overall responsibility

14. Every insurer shall ensure that all transactions in connection with micro-insurance business are in accordance with the provisions of the Insurance Act, 1938 as amended from time to time, the Insurance Regulatory and Development Act and the regulations and rules made there under.

Submission of information

15. Every insurer shall furnish the information in respect of micro-insurance business as specified by the Authority from time to time.

Obligations to rural and social sectors

16. All micro-insurance policies could be counted for the purposes of social obligations to be fulfilled by an insurer as per the provisions of the Insurance Act, 1938 and the regulations made there under. A micro-insurance policy, if issued in a rural area and comes under social sector definition, the policy may be counted for both under rural and social obligations separately.

Complaints/Grievances

17. It shall be the responsibility of the insurer to handle and dispose complaints against a "micro-insurance agent".

Inspection by the Authority

18. The Authority may through its designated officers inspect the office and records of the micro-insurance agent, at any time, if it considers necessary.

Report Card:LIFE

Life new business grows 68 %

The life insurance industry underwrote new business premium of Rs.1,86,605.46 lakh during the month of July, 2004, taking the cumulative premium underwritten during the current year 2004-05 to Rs.5,52,515.95 lakh. LIC underwrote premium of Rs.4,57,019.23 lakh i.e., a market share of 82.72 per cent, followed by ICICI Prudential and Birla SunLife with premium underwritten (market share) of Rs.31,173.97 lakh (5.64 per cent) and Rs.13,591.67 lakh (2.46 per cent) respectively.

While LIC's market share declined from 90.12 per cent for the period ended July, 2003, all new life insurers increased their market share, over the corresponding previous year numbers.

Cumulatively, the new players underwrote first year premium of Rs.95,496.72 lakh. In terms of policies underwritten, the market share of the new players and LIC was 8.30 per cent and 91.70 per cent as against 6.09 per cent and 93.91 per cent respectively in the corresponding period in the year 2003-04.

The premium underwritten by the industry upto July, 2004, towards individual single and non-single policies stood at Rs.81,244.37 lakh and Rs.3,39,644.37 lakh respectively accounting for 1,85,806 and 57,95,219 policies. The group single and non-single premium accounted for Rs.1,21,352.74 lakh and Rs.10,274.47 lakh. The total Individual premium and Group premium underwritten was Rs.4,20,888.74 lakhs and Rs.1,31,627.21 lakhs respectively as against Rs. 2,66,468.62 lakhs and Rs.62,636.22 lakhs underwritten in the corresponding period of the previous year. The number of lives covered by the industry under the various group schemes was 17,95,705 during the period ended July, 2004. LIC covered 11,89,843 lives under the group schemes accounting for 66.26 per cent of the market, followed by SBI Life with 1,70,035 lives (9.47 per cent), Tata-AIG with 1,13,730 lives (6.33 per cent) and MetLife with 78,883 lives (4.39 per cent).

> The life insurance industry underwrote new business premium of Rs.1,86,605.46 lakh during the month of July, 2004.

The accompanying table does not include the numbers for Varishtha Pension Bima Yojana. Premium underwritten by LIC under this pension scheme during the period April - July, 2004 was Rs.1,07,264.83 lakh towards 54,740 policies.

First Year Premium – July 2004

(Rs. in lakhs)

Sl No.	Company	Premium u/w		% of Premium	No. of Policies / Schemes		% of No. of Policies	No. of lives covered under Group Schemes		% of lives covered under Group Schemes
		July	Upto July	Upto July	July	Upto July	Upto July	July	Upto July	Upto July
1	**Bajaj Allianz**	**4,094.12**	**1,0675.20**	**1.93**	**20,634**	**53,427**	**0.89**	**27,754**	**49,066**	**2.73**
	Individual Single Premium	1,522.80	3,559.45		1,697	4,247				
	Individual Non-Single Premium	2,560.99	7,020.22		18,933	49,155				
	Group Single Premium									
	Group Non-Single Premium	10.33	95.52		4	25		27,754	49,066	
2	**ING Vysya**	**762.05**	**1,921.48**	**0.35**	**8,913**	**26,803**	**0.45**	**339**	**5,898**	**0.33**
	Individual Single Premium	0.19	32.44		27	4,771				
	Individual Non-Single Premium	708.33	1,778.20		8,885	22,026				
	Group Single Premium	53.01	95.26			1		123	255	
	Group Non-Single Premium	0.51	15.57		1	5		216	5,643	
3	**AMP Sanmar**	**372.04**	**1,302.03**	**0.24**	**2,696**	**9,616**	**0.16**	**2,597**	**17,956**	**1.00**
	Individual Single Premium	145.00	529.92		345	1,153				
	Individual Non-Single Premium	173.86	673.57		2,338	8,438				
	Group Single Premium	18.35	20.85		1	1		190	190	
	Group Non-Single Premium	34.83	77.69		12	24		2,407	17,766	
4	**SBI Life**	**3,357.41**	**8,460.42**	**1.53**	**9,296**	**26,515**	**0.44**	**73,737**	**1,70,035**	**9.47**
	Individual Single Premium	705.89	1,986.43		418	1,144				
	Individual Non-Single Premium	508.85	1,573.69		8,468	24,759				
	Group Single Premium	1,046.04	3,257.56		1	2		13,381	40,165	
	Group Non-Single Premium	1,096.63	1,642.74		409	610		60,356	1,29,870	

(Rs. in lakhs)

Sl No.	Company	Premium u/w		% of Premium	No. of Policies / Schemes		% of No. of Policies	No. of lives covered under Group Schemes		% of lives covered under Group Schemes
		July	Upto July	Upto July	July	Upto July	Upto July	July	Upto July	Upto July
5	**Tata AIG**	**2,556.48**	**7,551.74**	**1.37**	**17,830**	**64,420**	**1.08**	**31,880**	**1,13,730**	**6.33**
	Individual Single Premium									
	Individual Non-Single Premium	1,688.16	5,704.18		17,797	64,344				
	Group Single Premium	47.47	198.62					6,602	29,094	
	Group Non-Single Premium	820.85	1,648.94		33	76		25,278	84,636	
6	**HDFC Standard**	**2,347.73**	**7,658.62**	**1.39**	**17,003**	**43,755**	**0.73**	**17,723**	**52,045**	**2.90**
	Individual Single Premium	642.44	2,104.99		1,655	4,632				
	Individual Non-Single Premium	1,566.72	5,147.12		15,336	39,066				
	Group Single Premium	79.45	245.57		11	53		17,243	44,216	
	Group Non-Single Premium	59.12	160.94		1	4		480	7,829	
7	**ICICI Prudential**	**8,993.41**	**31,173.97**	**5.64**	**43,447**	**1,42,814**	**2.39**	**705**	**6,690**	**0.37**
	Individual Single Premium	1,514.21	5,863.79		1,011	3,565				
	Individual Non-Single Premium	7,171.05	21,985.78		42,429	1,39,204				
	Group Single Premium	4.58	11.59		2	5		192	850	
	Group Non-Single Premium	303.57	3,312.81		5	40		513	5,840	
8	**Birla Sunlife**	**4,229.52**	**13,591.67**	**2.46**	**12,739**	**36,411**	**0.61**	**7,039**	**14,256**	**0.79**
	Individual Single Premium	136.49	430.59		2,450	6,450				
	Individual Non-Single Premium	3,770.42	10,616.21		10,280	29,936				
	Group Single Premium	38.76	138.18					314	1,121	
	Group Non-Single Premium	283.85	2,406.70		9	25		6,725	13,135	
9	**Aviva**	**1,283.15**	**4,542.67**	**0.82**	**6,354**	**23,816**	**0.40**	**10,618**	**39,076**	**2.18**
	Individual Single Premium	15.66	147.90		37	142				
	Individual Non-Single Premium	1,236.29	4,308.27		6,316	23,662				
	Group Single Premium	1.92	4.39			1		14	43	
	Group Non-Single Premium	29.28	82.11		1	11		10,604	39,033	
10	**Kotak Mahindra Old Mutual**	**829.02**	**2,547.54**	**0.46**	**3,941**	**11,704**	**0.20**	**779**	**27,197**	**1.51**
	Individual Single Premium	270.33	560.59		169	357				
	Individual Non-Single Premium	556.31	1,522.11		3,770	11,340				
	Group Single Premium									
	Group Non-Single Premium	2.38	464.83		2	7		779	27,197	
11	**Max New York**	**1,863.72**	**4,896.90**	**0.89**	**19,239**	**50,126**	**0.84**	**3,843**	**31,030**	**1.73**
	Individual Single Premium	25.67	91.57		42	84				
	Individual Non-Single Premium	1,825.71	4,752.18		19,188	50,015				
	Group Single Premium									
	Group Non-Single Premium	12.34	53.15		9	27		3,843	31,030	
12	**MetLife**	**370.07**	**1,174.48**	**0.21**	**2,621**	**7,325**	**0.12**	**11,874**	**78,883**	**4.39**
	Individual Single Premium	17.76	38.71		33	91				
	Individual Non-Single Premium	267.45	822.30		2,580	7,204				
	Group Single Premium									
	Group Non-Single Premium	84.86	313.47		8	30		11,874	78,883	
13	**LIC**	**1,55,546.73**	**4,57,019.23**	**82.72**	**18,57,036**	**54,88,955**	**91.70**	**4,04,097**	**11,89,843**	**66.26**
	Individual Single Premium	36,288.57	65,897.98		90,537	1,59,170				
	Individual Non-Single Premium	90,836.93	2,73,740.53		17,65,413	53,26,070				
	Group Single Premium	28,421.23	1,17,380.72		1,086	3,715		4,04,097	11,89,843	
	Group Non-Single Premium									
	Total	**1,86,605.46**	**5,52,515.95**	**100.00**	**20,21,749**	**59,85,687**	**100.00**	**5,92,985**	**17,95,705**	**100.00**

Note: LIC's business numbers exclude Varishtha Pension Bima Yojana.

Financial Reporting for Life Insurers

—Canada & India: A Comparison

Shriram Mulgund

We all experience situations that are just coincidences. This article got written out of one such coincidence. One of the members of the Actuarial Society of India (ASI) sent me an e-mail asking me questions about the manner in which the financial reporting for life insurers takes place in Canada. While compiling the information to answer the questions, I realised that the note could become an article that could be sent for publication. So, here it is.

This article gives a very broad description of the basis of financial reporting for life insurance companies in Canada in respect of the following:

- Valuation of assets
- Valuation of liabilities
- Solvency margins

The description is short in most places. If anyone needs to know further details, I will be happy to elaborate.

The Indian practice for valuation of liabilities has a lot of similarities with the Canadian practice. Valuation of assets is very much guided by the accounting practices followed by the accounting profession in the country. While it is not suggested that the Canadian practice may be appropriate for duplication in India, knowing the practices followed in other parts of the world may have some benefits – particularly in the area of solvency margins, where some changes may be forthcoming if a move to Risk Based Capital approach is to be made. In Section D, I have compared the Canadian practice with the Indian practice and in Section E I have put forth my thoughts on where changes to the Indian practice may be considered.

A. Valuation of Assets

1. General approach

The approach used for valuation of assets depends on the asset class – bonds, mortgages, equities and real estate. The basic objectives in the methods adopted are three-fold:

- To effect a smooth progression of values from the purchase price to the maturity value for fixed income assets.
- To take into account the effect of changing market values for equities and real estate in a smoothed manner, thus avoiding wide fluctuations from one year to the next, and permitting the benefit of market value growth to policyholders and shareholders through additional investment income.
- To make the effect of the decision to hold or sell an investment revenue-neutral, so that the profits of the year are not unduly affected by such decisions.

Knowing the practices followed in other parts of the world may have some benefits – particularly in the area of solvency margins.

The following paragraphs describe how different asset classes are dealt with.

2. Bonds

Bonds are valued at amortised cost. Thus, if a bond maturing for 100 is bought at 85, the discount of 15 is amortised over the term of the bond. As the value of the bond is written up, the amount of write-up is brought into investment income for that year. Such write up augments the dividend income paid by the bond. Similar treatment is given to bonds that are bought above par. Regardless of the market value, the bond is valued at amortised cost.

If the bond is sold prematurely, the amount of realised capital gains or losses (equal to sale price less the amortised cost) is amortised over the remaining term of the bond in a straight-line manner. Thus, if a bond with a remaining term of 10 years and an amortised cost of 90 is sold for 110, the realised capital gain of 20 is amortised over the 10-year period in equal amounts.

The purpose behind the above treatment of capital gains is to make the sale transaction revenue-neutral. Thus, whether the bond is held or sold for profit (or loss), the amount of investment income reflected in the financial statements will not be meaningfully different – minor differences may arise since the two streams of amortisation amounts (before and after sale) will be slightly different.

If any bond becomes impaired, its value will be written down with the amount of write-down being reflected as a charge for the year's profits.

3. Mortgages

Mortgages are valued at the amounts of outstanding loans. These will generally be held to maturity. If a mortgage is sold prematurely, the amount of capital gain or loss (equal to the sale price minus the amount of outstanding loan) is amortised over the remaining term of the mortgage in a straight-line manner (similar to bonds).

The treatment for impaired mortgages is similar to that for bonds.

4. Equities

In the first valuation after a stock is put on the books, 7.5 per cent of the unrealised capital gain (or loss) is brought into investment income for the year and the value of the stock is increased (decreased) by the corresponding amount. In the following years, any unrealised capital gain (or loss) is determined with reference to the amortised cost of the stock and the process of amortisation is continued.

If a stock is sold, the full amount of realised capital gain or loss (determined with reference to the amortised cost) is not considered as investment income for that year. In order to smooth the effect of the sale transaction, each year 7.5 per cent of the outstanding amount of realised capital gain or loss is brought into investment income and the outstanding amount of realised capital gains is reduced by the corresponding amount.

The above treatment has a number of characteristics. Firstly, the value placed on the investment is continually updated to reflect the movement of market values. Secondly, the use of amortisation at 7.5 per cent avoids the wide fluctuation of asset values from one year to the next. Thirdly, the treatment of realised capital gains ensures that whether the stock is held or sold, the investment incomes for that year and the succeeding years are not affected to the extent of the unrealised capital gain at the time of sale.

5. Real Estate

The treatment for real estate is identical with that for equities with one difference – the amortisation rate is 10 per cent instead of 7.5 per cent. There is a requirement that all real estate holdings have to be independently appraised at least once in three years. The insurers will generally value all major holding internally each year.

6. Other investments

Standard accounting practices are followed for other assets (e.g. cash, short term securities, prepaid expenses, office equipment, etc.).

7. Manner of reflecting Realised Capital Gains

As indicated above, the realised capital gains are amortised over the future years. The total amount of unrealised capital gains is shown on the balance sheet as a liability – thus the net value of assets will be equal to value of investments held minus the amount of the liability represented by the total amount of unamortised capital gains. As each year passes, the total amount of unamortised capital gains is decreased (using the different bases described above) and the value of investments held is written up. Any unamortised realised capital losses are given a similar treatment.

B. Valuation of Liabilities

8. General description of the valuation method

The valuation method is called Canadian Asset Liability Method (CALM). The principal features of this method can be described as follows:

In adopting the RBC approach, it has to be borne in mind that the level of solvency margin cannot be considered in isolation – it is the total of the reserve and the required solvency margin that has to be taken into account.

- The valuation method is applied to groups of policies where the insurer is expected to apply a specific asset-liability management practice (e.g. single premium annuities in payment, universal life, non-participating life insurance, etc.). This method envisages an identifiable basket of assets that is associated with that block of business.
- The method involves scenario testing – i.e. use of a variety of interest rate scenarios with compatible assumptions for other parameters. Each scenario is expected to give a different reserve level. The actuary then uses the results of the scenario that makes sufficient (without being excessive) provision for adverse deviations.
- For each interest rate scenario, the asset and liability cash flows are generated for all future years (until the last liability payment is made). The fund is rolled forward, with the positive net cash flow being re-invested under the then investment conditions (implied by the interest rate scenario) and the insurer's investment strategy for that block of business. Any negative net cash flows are met through sale of assets or through a loan based on the disinvestment strategy. The amount of surplus in the fund is determined when the last liability payment has been made. Depending on the ultimate level of the surplus, the initial basket of assets is increased or decreased and the next iteration is started. This iterative process is continued until such time that the ultimate surplus in the fund becomes zero. After the final iteration, the statement value of the modified basket of assets supporting that block of business becomes the reserve level.
- As indicated above, each scenario will give a different reserve level. The highest level (from amongst those providing plausible adversity) becomes the final reserve level used in the financial statements.

9. Steps involved in the application of CALM

The following steps are involved in the application of CALM.

(a) Interest rate scenarios

The interest rate scenarios entail future yield curves, spreads for different risk classes of bonds and

for mortgages, yields from equities and real estate, market value growth rates for equities and real estate, inflation rates, asset default rates, etc.

(b) Asset cash flows

In computing the cash flows in respect of the assets on hand, the effect of asset defaults, pre-payment or call options and investment expenses will be taken into account. The growth in the market value of equities and real estate will also be taken into account. The values of some of the parameters may depend on the interest rate scenario (e.g. the asset defaults may increase under some scenarios, the level of exercise of call options or pre-payment options may depend on the scenario).

(c) Liability cash flows

The liability cash flows will be established in respect of the business in force at the valuation date. In computing these cash flows, all relevant parameters (depending on the type of business) have to be taken into account in an explicit manner. The manner in which the levels of these parameters will be established is discussed in Section 10 below.

(d) Application of CALM in practice

The method described above can be applied for uniform blocks of business. If such a valuation is performed on the actual business in force at the year-end, no further calculations are needed. This method does not need any calculation of reserves at the policy level. In practice, some variations are found necessary for the following reasons:

- The scenario testing involves complex calculations. It entails use of scenarios and changing assumptions, possible use of stochastic techniques (requiring the use of models), etc. The timing at the year-end may be such that such calculations cannot be performed at that time. To overcome this difficulty, the reserve level for that block is determined ahead of time (using the business in force at that time). Once the reserve level has been established, the rate of interest at which the present value of the liability cash flow is equal to the reserve level just established is determined. This then becomes the valuation rate of interest. This interest rate is then applied to the actual business in force at the end of the year for that block of business – subject to any modifications for any material changes in circumstances that may have taken place between the date of testing and the year-end.
- For many purposes, the reserves at the policy level are required – e.g. for determining negative reserves or cash value deficiencies, for computing the solvency requirements, etc. When the above approach to determine the valuation rate of interest is used, reserves at the policy level can be computed for the business valued at the year end.

10. Liability valuation bases

As described above, CALM entails the computation of liability cash flows. In computing these cash flows, a number of parameters have to be taken into account. These depend on the product type. Generally speaking, these will consist of mortality, surrenders lapses, conversion from term to permanent plans, premium persistency, policy expenses (with an allowance for inflation), incidence of disability, termination of disability, etc. In choosing the assumptions for each of these parameters, following considerations have to be taken into account:

- Each assumption should consist of two components – Best Estimate assumption and a Margin for Adverse Deviation (MfAD).
- The Best Estimate assumption should be appropriate for the product to be valued and should be based, where possible, on the insurer's own experience. If such experience is not available, it can be based on the industry experience.
- The MfAD is added to allow for the possibility that the Best Estimate assumption may not have been determined accurately. The level of MfAD will depend on the degree of confidence in the Best Estimate assumption – lower the confidence, greater the MfAD and vice versa.
- It should be noted that the level of some of the parameters may depend on the interest rate scenario, e.g. the surrenders/ lapses, expense inflation, etc.

11. Special features

There are some special features that would be of interest:

- The reserve under a policy can be negative or less than the guaranteed cash value. Such deficiencies are taken into account at the time of computing the solvency margins.
- For contracts with very little death benefits, such as segregated fund (mutual fund) contracts, the "term of contract" is defined in such a manner that the absolute value of any negative reserve does not exceed the unamortised acquisition costs.

12. Professional guidance to actuaries

The Canadian Institute of

Actuaries (CIA) has provided very detailed professional guidance to the members in respect of the application of CALM – steps in working CALM, choice of interest rate scenarios, determination of Best Estimate assumptions, level of MfAD's for different assumptions, etc.

C. Solvency Margins

13. General approach to Solvency Margins

The Office of the Superintendent of Financial Institutions (OSFI), the Canadian insurance regulator, has published a very detailed guideline for the computation of the solvency margins. The solvency margins, known as Minimum Continuing Capital and Surplus Requirements (MCCSR), are based on Risk Based Capital approach. A minimum level of $5 million is specified. The MCCSR level is compared with the Available Capital to determine the MCCSR Ratio (Available Capital divided by the MCCSR).

In the following description, a number of finer points have been glossed over.

Components of the MCCSR

The MCCSR consists of the following five risk components:

- Asset defaults (C-1) risk – losses caused by defaults in payments.
- Mortality, morbidity and Lapse risk – the risk that the assumptions may be wrong.
- Interest margin pricing risk - the risk of interest margin losses with respect to invested assets and pricing decisions (other than the losses from asset defaults and changes in interest rate environment).
- Changes in interest rate environment (C-3) risk – the risk of loss resulting from changes in interest rate environment.
- Segregated fund risk – the risk of loss from guarantees embedded in segregated fund contracts.

Available Capital

The Available Capital consists of two tiers – Tier 1 (Core capital) constitutes the highest quality capital and Tier 2 (Supplementary capital) constitutes capital not of highest quality but contributing to the overall strength of the insurer as a going concern. Certain restrictions apply to the levels of capital under these tiers.

MCCSR Ratio

A minimum ratio of 120 per cent is specified. The reason for a ratio in excess of 100 per cent is that the MCCSR calculation process does not explicitly address many risks, such as risks relating to systems, data, strategic direction, management, fraud, legal and other business risks or any risks not explicitly addressed by the actuary when determining the policy liabilities.

> Adoption of practices followed by another jurisdiction without modification is at times difficult or impractical.

The insurers are advised to retain a minimum ratio of 150 per cent to provide a cushion above the minimum to cope with the volatility in the marketplace and economic conditions, innovations in the industry, consolidation trends and international development.

14. Available Capital

As indicated above, the Available Capital consists of two tiers.

Tier 1 (Core Capital)

This consists of the following components:

- Common shareholders' equity – common shares, contributed surplus and retained earnings.
- Qualifying non-cumulative perpetual preferred shares.
- Participating account.
- 55 per cent of realised capital gains in respect of surplus assets (equal to 100 per cent of such gains less taxes).

From this amount a deduction is made for goodwill, cash surrender value deficiency (viz. reserves less than cash values) computed on an aggregate basis and negative reserves computed on a policy-by-policy basis. (Note: The cash surrender value deficiency is calculated for uniform blocks of business. Since the calculation is done on an aggregate basis, any excess of reserves over the cash values from some policies can offset deficiencies under others.)

Tier 2 (Supplementary Capital)

This is in turn split into three components 2A, 2B and 2C. These include the following:

- Hybrid (debt/equity) capital instruments – cumulative perpetual preferred shares, 99-year debentures, etc.
- Limited life instruments – subordinated term debt and term preferred shares.
- 75 per cent of the cash surrender value deficiency computed on aggregate basis.
- 75 per cent of negative reserves computed on a policy-by-policy basis.
- Unrealised unamortised capital gains in respect of surplus assets less a provision for taxes.
- 50 per cent of terminal dividend reserves in respect of out-of-Canada policies.

Deductions and limitations

From the total of T-1 and T-2 capitals, a deduction is made for policy liability ceded to unregistered reinsurers. A number of limitations are applied, e.g.

- T-2 capital should not exceed T-1 capital.
- Negative reserves included in T-2 should not exceed 33 per cent of T-1.

15 Asset default risk (C-1 Risk)

In quantifying this risk, off-balance-sheet assets are also considered. The default factors depend on the type and quality of asset. For assets supporting qualifying participating business, the factors are reduced by 50 per cent to allow for the pass through features of such policies (a default loss can be passed on the policyholders through reduced benefits). The factors given below represent the full factors. Assets backing index-linked products attract separate capital factors based on correlation calculations.

The MCCSR guideline gives a detailed description of the various factors. The following is a broad description of the factors used:

- Cash, policy loans, receivables from registered insurers, etc. – 0 per cent.
- Outstanding premiums, agents' balances, receivables, prepaid expenses, receivables from non-approved reinsurers, etc. – eight per cent.
- Short-term securities (under one year) – Factors range from 0 per cent (for Govt. securities) to two per cent for commercial paper rated R3, A-3 or equivalent.
- Bonds – Factors range from 0 per cent (Govt. securities) to 16 per cent (lower than B, C or equivalent).
- Mortgages – Factors range from two per cent (residential first mortgages) to 8 per cent (mortgages on undeveloped land).
- Equities – For preferred shares, factors range from one per cent (Pfd-1) to 15 per cent (Pfd-5). For common shares and mutual funds – 15 per cent.
- Real Estate – Factors range from four per cent (self-occupied premises) to 35 per cent (oil and gas properties).
- For impaired investments, an additional component of 35 per cent less amounts of individual allowances and write-downs. This component should not be negative.
- For restructured loans and mortgages, a factor of 15 per cent is used.
- For assets supporting index-linked products, asset default factors are replaced by capital factors. These require the calculation of Correlation Factors (CF) that take into account the returns credited to policyholder funds, returns on supporting assets and their standard deviations. The capital factors are equal to (100 – CF) per cent.

16 Mortality/morbidity and lapse risk

Various factors are applied to the measure of exposure that depends on the type of business:

- Life insurance – Net sum at risk (sum assured less reserve).
- Annuities (with life contingency) – Policy liability.
- Disability income (new claims) – Annual premium.
- Disability claims (in course of payment) – Policy liability.

The factors depend on the period of guarantee remaining for the benefits provided.

(a) Mortality

The factors are per 1,000 of exposure.

Group life insurance

- Participating. Guarantee less than one year – 0.5. Others – 1.0.
- Non-participating. Guarantees less than one year, one to five years and over five years – 0.5, 1.0 and 2.0 respectively.

Individual life insurance

- Participating – 1.0.
- Non-participating. Universal Life – 1.0. Others - Guarantees less than one year, one to five years and over five years – 0.5, 1.0 and 2.0 respectively.

Accidental death and dismemberment

- Multiply above factors by 30 per cent to reflect the proportion of accidental deaths.

The component is reduced for reinsurance ceded to approved reinsurers. For qualified stop loss arrangements, the ceding company can reduce the component by an amount not exceeding 40 per cent of the amount.

The above amounts are then adjusted for statistical fluctuation by multiplying by a factor ranging from 1.25 (calculated component up to $1 million) to 0.60 (calculated component over $1 billion).

Annuities involving Life contingencies

- One per cent of reserves (including any portion of liability that does not involve life contingency).

17 Morbidity

New Claims Risk (% of Annual Premium)

- Factors for guarantee periods less than one year, one to five years and over five years – Individual (12, 20, 30 respectively), Group (12, 25, 40 respectively).

- Above factors are multiplied by 75 per cent if the benefit period does not exceed two years.

Continuing claims risk

- Factors depend on the duration of disability and length of benefit period remaining and range from two per cent to eight per cent of reserve.

Accident and sickness

- New Claims – 12 per cent of annual premium.
- Continuing Claims – 10 per cent of IBNR relating to prior years.

The calculation is done net of reinsurance ceded. Adjustment factors for statistical fluctuation range from 1.00 (calculated component upto $10 million) to 0.75 (calculated component over $100 million).

18 Lapses (individual business only)

This component is calculated in the following steps:

- Group the business in Group A (reserves are higher with lower lapse rates for durations six and over) and Group B (reserves are higher with higher lapse rates for durations six and over).
- Recalculate the reserves with lapse rates for Group A being lower by 10 per cent and for Group B being higher by one percentage point. For participating business, 50 per cent values are used.
- The increase in the reserve is the lapse component of the MCCSR.

19 Interest margin pricing risk

This provides for losses in interest arising from such events as communication problem between the investment and pricing personnel, lack of sufficient volumes of new bond and mortgage opportunities and change in the interest spreads relationships between different investments.

- For life insurance and A&S business, the component is 0.5 per cent of reserves for participating and adjustable business and one per cent of reserve for non-participating business.
- No component is needed for Guaranteed Interest type of contracts where the terms at next renewals are the same as for new business. For other situations, the factor is 0.5 per cent.
- No component is needed for business where there is no re-pricing risk – e.g. paid up business with no future dividends or when the policy liabilities are not discounted for interest – e.g. unearned premiums.

Change the treatment of realised capital gains so that it becomes transaction-neutral.

20 Changes in interest rate environment (C-3 Risk)

(a) Policy liabilities

This covers the risk of asset depreciation arising from interest rate shifts. The component is calculated on net of ceded basis. The reserves are taken net of policy loans if the loan rate is variable and has no upper limit. The factors are reduced by 50 per cent if the policy has no guaranteed cash value in the next five years. No component is required for business where the policy liabilities are not discounted for interest or there is no interest credited.

Non-participating (factors are per cent of reserves)

- Life and Health (other than Universal Life) - Factors depend on the period of premium guarantee remaining. Factors for periods under five years, five to 10 years and over 10 years are 1.0, 2.0 and 3.0 respectively.
- Endowment. Factors for the above remaining guarantee periods are 1.5, 3.0 and 5.0 respectively.
- Single premium annuities and disability claims – 1.0.

Participating and Universal Life

- Non-participating factors for the lowest guarantee period are used.

Accumulation funds

- The factors depend on how the funds can be withdrawn (with or without an adjustment for changes in interest rates), how the withdrawn amount can be paid (single sum, an annuity or in installments) and the remaining period of interest guarantee. The factors range from 0.5 per cent to 10.0 per cent of the reserve.

(b) Asset cash flow uncertainty risk

This provides for risk arising from prepayment and extension of debt instruments that are sensitive to interest rates. The following factors are applied to the value of assets:

- Residential and commercial mortgages that have no prepayment penalties or conditions – one per cent.
- U.S. Mortgage Backed Securities (MBS) and Collateral Mortgage Obligations (CMO) – Factors are based on "Cash Flow Uncertainty Index" and range from 0.5 per cent to 75 per cent.
- Other fixed income assets – Testing is needed for different interest rate scenarios to determine the Cash Flow Uncertainty Index. The factors range from 0.5 per cent to eight per cent.

- For any assets that are supporting cash flow tested reserves, the factors are reduced by 50 per cent.

21 Off Balance sheet activity risk

This covers the risk of the counter party to a transaction, i.e. the credit risk. The face amount of the off balance sheet instrument does not always reflect the amount of credit risk. The potential exposure can be measured by the face amount of the instrument multiplied by a "credit conversion" factor. This is then multiplied by the MCCSR factor.

The credit conversion factors range from 100 per cent to 0 per cent (commitments with an original maturity of one year or less or that are unconditionally cancelable at any time without prior notice). The MCCSR factors range from 0 per cent to 8 per cent. The factors applied to qualified participating business are 50 per cent of these factors.

22 Segregated fund guarantee risk

This covers the risk of the minimum benefits guaranteed under segregated fund contracts. This calculation is done through a series of steps.

Basic factor A1

The factors depend on the following:

- Years to maturity.
- Whether or not resets are permitted.
- Level of minimum death, surrender and maturity benefit.
- Type of fund.

The factors range from 0.01 per cent to 27 per cent. Separate factors are specified for minimum death, maturity/surrender and income benefits.

Time Diversification Adjustment A2

An adjustment is made for companies having guarantee maturities that are sufficiently spread over time. These factors range from 1.000 to 0.905.

MV/GV and Time to Maturity Adjustment B

An adjustment is made for the relationship of the current Market Value to the Guaranteed Value and the time to maturity. The factors depend on the ratio of MV/GV, years to maturity and whether or not resets are permitted.

MER Adjustment C

This is an adjustment reflecting the differences in the actual Management Expense Ratios from those assumed in developing the factor tables.

Margin Offset Adjustment

This reflects the reduction to take into account the margins that are available in the products.

D. Comparison with Indian practice

23 General observations

As indicated at the beginning of the article, financial reporting practices in different countries have developed along different historical lines. In looking at the practices followed by other jurisdictions, it is always informative to appreciate the logic inherent in those practices. That may be of help in deciding the future course of action if a change is contemplated.

While comparing the international practices, the development on the international scene has also to be borne in mind. There is a move to Fair Value Reporting. This may bring in changes in the manner in which the financial reports of life insurers may be prepared. This includes the use of Risk Based Capital approach for solvency margins. The following sections compare the Canadian practice with the Indian practice in the three areas discussed above.

24 Valuation of assets

Bonds

The primary feature for bonds is the amortisation of premiums or discounts. In both countries the premium or discount is brought into investment income each year and the bond price is written up/down.

There is a major difference in the treatment of a sale transaction.

- In Canada, the accounting practice is transaction neutral. Any gain (or loss) is amortised in a straight-line manner over the remaining term of the bond. Thus, apart from any variation in the incidence of the amortisation amounts (before and after sale), the sale has no effect on the financial statements. Such straight-line amortisation is dictated by practical considerations so that all bonds with same remaining terms can be grouped together (without having to retain the original terms of the bonds after they have been sold).
- In India, any capital gains (or losses) flow through the financial statement for the year of sale. As a result, an insurer sitting on a sizable amount of unrealised capital gains can sell and repurchase the bonds and bring in the profits during the year of sale. Even though transaction costs have to be incurred, the accounting practice may dictate the sale transactions and could be misused.

Mortgages

Even though the mortgages are unlikely to be sold prematurely, the comments for bonds equally apply to mortgages.

Equities

There are major differences between the Canadian and Indian practices.

- The Canadian practice is based on market values. In order to smooth the market value fluctuations, only 7.5 per cent of the excess of the market value over the carrying value is brought into the revenue account each year. It is transaction neutral. Thus, any capital gains arising from any sales are amortised using the same factor. Also, no distinction is made between the policyholder funds and the shareholder funds.
- The Indian practice is to use cost basis. Thus, any unrealised capital gains are offset by a corresponding increase in Fair Value Change Account. A portion of the unrealised capital gains can be brought into revenue for bonus declarations subject to IRDA approval. It appears that for any equities supporting non-participating, the benefit of any unrealised capital gains cannot be passed on to the fund (unless it is sold). The revenue account can be influenced by a sale transaction (or a sale and buy back transaction). Also, the treatment between the policyholder fund and shareholder fund is not the same.

Real Estate

The differences described for equities equally apply to real estate (in Canada, the amortisation rate for real estate is 10 per cent instead of 7.5 per cent for equities). There are other major differences.

- In Canada, no distinction is made between real estate held for investment and that is owner-occupied. For owner-occupied properties, a rent at the going market rate is imputed. This has two effects. Firstly, the yield on the property is realistic. Secondly, the use of imputed rent results into a realistic determination of the administration costs for the business that eventually get built into the pricing of products and for determining the valuation assumption for expenses.
- In India, the treatment of owner-occupied real estate may (will) introduce an element of understatement in the level of expenses that will flow into pricing and valuation. Such treatment of expenses will be disadvantageous for the new insurers who may not be holding any owner-occupied properties and will show higher expenses resulting from paying rents at the current market values. In all probability, since such real estate will be held by the shareholder funds, the shareholder profits will be understated.

The accounting treatment given to an investment should depend on the nature of investment and not by where it is held (Policyholders' Fund or Shareholders' Fund)

25 Valuations of liabilities

The approaches used for valuation in the two countries are very similar. Both use an explicit approach that recognises all future cash flows, use assumptions for all contingencies and employ the concept of "expected" assumptions and "margins for adverse deviations". The following could be considered as some of the major differences:

- The Canadian approach uses asset-liability cash flow testing (along with a multitude of economic scenarios) to the full extent. The Indian practice indicates the need for such testing in the determination of the interest rate assumption but is not ingrained in the professional practice.
- The Canadian Institute of Actuaries has provided an extensive amount of guidance to the profession in matters such as determining best estimate assumptions, determining margins for adverse deviations, scenario testing, etc. It will appear that the ASI may have to put in more efforts in providing assistance in these matters.
- The most prominent difference lies in the treatment of negative reserves and any reserves less than the guaranteed cash values. No minimums are used for such values in Canada. The thinking behind this approach is that once the Appointed Actuary has determined the valuation assumptions (that include margins for adverse deviations) there is no need to put any artificial limitations on the reserve levels. With such approach, the financial statements reflect realistic earnings. Any concerns arising from the solvency considerations are reflected in the MCCSR computations (the asset created by such reserves is considered to be belonging to Tier 2).

26 Solvency Margins

Required Solvency Margins

The Canadian practice uses the Risk Based Capital approach. Significant amounts of effort have gone into identifying the various risks and quantifying them.

In India, even though the modified Insurance Act envisages

the use of a three-factor approach, the Regulations specify only two factors. The third factor for asset defaults was (temporarily?) set to zero – primarily due to the opposing views of some members of the profession when the discussions were going on. The present two-factor approach essentially follows the U.K. practice. Use of an RBC approach that is appropriate to the Indian environment would have taken a lot of research. Due to the then time pressure, it was quite natural to use an approach followed by some jurisdiction.

In adopting the RBC approach, it has to be borne in mind that the level of solvency margin cannot be considered in isolation – it is the total of the reserve and the required solvency margin that has to be taken into account.

Available Capital

Under the Canadian approach, credit is given to all the capital gains (realised and unrealised). In respect of the policyholder funds, such credit is given through the approach used for cash flow testing (that recognises all unrealised capital gains). In respect of the shareholder funds, the credit is given in determining the amount of available capital (with an allowance for any taxes that may be payable when such gains are realised).

The Indian approach in respect of any unrealised capital gains is mixed. It will appear that these are permitted only in respect of real estate held for investment by the policyholder funds and not available for others (owner-occupied real estate, equities and all Shareholders' Funds). This will undoubtedly cause a strain on the insurers in requiring to raise additional capital.

E. Possible changes in the Indian practice

As indicated at the beginning of the article, the life insurance industries in different countries would have developed on different lines. As a result, adoption of practices followed by another jurisdiction without modification is at times difficult or impractical. Nevertheless, it is hoped that the above description of the Canadian practice and a comparison with the Indian practice may be helpful if some changes are contemplated. The worldwide move in the direction of fair value accounting also has to be taken into account.

Bring consistency in the treatment of both sides of the balance sheet.

Consideration can be given to the following changes:

- Bring consistency in the treatment of both sides of the balance sheet. At present, while on the liability side, the valuation of liabilities attempts to use a fair market value approach, the approach used on the assets side is still on the book value basis. A change can be considered to use market value basis on the assets side. This can be done by using market values directly or by using some form of smoothed market values as done in Canada. Such change will put the financial statements on a compatible basis.
- Change the treatment of realised capital gains so that it becomes transaction-neutral. Whether an investment is held or sold should not affect the financial statement.
- The accounting treatment given to an investment should depend on the nature of investment and not by where it is held (Policyholders' Fund or Shareholders' Fund) or is deemed to be an investment property or an owner-occupied property.
- In valuing the liabilities, any reserves that are negative or less than the guaranteed cash values need not be set to a minimum. Any solvency considerations should be reflected in the Solvency Margin levels.
- The Minimum Solvency Margins can be based on the RBC approach. This will undoubtedly require a fair degree of research into identification and quantification of the applicable risks. The amount of available capital should recognise any unrealised capital gains on all investments that have not been taken into account in valuing the liabilities – whether such investments are held in the policyholder fund or the shareholder fund.

Making any of the changes will involve a number of players – such as the IRDA, the Actuarial Society of India and the Institute of Chartered Accountants. Getting a consensus may not be easy!

The author, an actuary, retired after spending over 40 years in the life insurance industry. He has been very active on the Indian insurance scene.

Are the Protectors Protecting Themselves?

— Insurers, risk managers and their corporate activities

G. V. Rao

Risk management by insurers, essentially, is about reducing their vulnerability due to the changes taking place within their organisations and in the environment in which they function. Currently, each department of an insurer such as the finance, human resource, marketing and technical is left to deal with its risk exposures independently in its own way and in a piece-meal fashion. There is no corporate-wide view of risk management of these changes as a corporate strategy to build synergies across all departments to ensure healthy cash flows on a sustainable basis.

Insurers do not as a rule analyse their risk exposures that have an impact on their bottom line due to their internal inefficiencies and deficiencies, the competitive zeal of others, the changing customer attitudes, the likely changes in the Government and regulatory policies and the pressures from stakeholders, as a matter of best business practice. In the fast changing current market conditions, there is, however, a greater need for insurers to develop risk management plans that are approved by their boards of directors, particularly as there is no statutory or regulatory compulsion for the boards to do so.

Enterprise Risk Management

Insurers perhaps occasionally do put into practice mechanisms to deal with 'known risks and changes' that are mostly internal and mostly apparent. These are treated as a part of 'Change Management.' But risk factors whose consequences are unknown, operating mostly in the external environment, can more severely affect insurance enterprises. Insurers should, therefore, frequently scan the environment for possible scenarios that might affect them to be able to put in practice mechanisms that would mitigate their financial consequences of such unknown factors or risks. 'Change management' and 'Risk management' should both be accorded a higher priority.

Recently, 14 life insurance companies in Nigeria were shut down by the Government of Nigeria for their failure to meet capital adequacy norms prescribed under the statute. Barings, a British Bank of 233 years standing, was sold to ING for one pound plus losses, following the activities of one rogue trader, Nick Leeson, on account of inadequate supervision over his functions. Oman National Insurance Co SAOG, in the Sultanate of Oman, that had a market share of 40 per cent collapsed in 2000 due to negligent reinsurance arrangements that escaped corporate scrutiny. These incidents occurred due either to unknown and sudden risk factors; or unacknowledged internal inefficiencies. There was no management appreciation of operational risks and what could go wrong with its systems that would put the whole enterprise to huge financial losses.

> A survey by the Financial Services Authority (FSA), UK to determine what caused the failure of several insurers and reinsurers concluded that the major reason was the inability of managements to predict events and forecast their consequences

Following the collapse of Enron and other corporations in US, the Sarbanes-Oxley Act, 2000 enjoins the boards of corporations in US to be responsible for disclosing to the shareholders that there are in place processes to manage potential threats to their balance sheets. Financial organisations that deal with public funds need stricter risk management corporate controls to deal with internal and external risk exposures both for survival and growth.

What led to the recent collapse of insurance markets abroad?

Anticipating and forecasting the consequences of the rapid and, occasionally, inevitable changes taking place within the organisation and outside of it have not been the topics of intense discussions at the corporate level among the insurers. While insurers are regarded as reasonably good as risk managers of their customers' physical risk exposures, they are found to be woefully wanting when it comes to managing their own corporate risk exposures.

A survey carried out recently by the Financial Services Authority (FSA), UK to determine what caused the failure of several insurers and reinsurers - that followed the recent collapse of the international insurance markets in 2002 - concluded that the major reason was the inability or neglect of managements in anticipating the events that occurred and forecasting their consequences on the cash flows and the margins and not having contingency plans to deal with the unfolding developments. Managements were to blame more than the events that occurred.

This article proposes to deal with the identification of major risk exposures faced by insurers either due to operational business risks or due to changes in the external environment that could cause them severe financial impact; and why an enterprise risk management strategy plan is necessary for their survival and growth. It is beyond the scope of this article to deal with the issues of evaluating their impact and how best an insurer could deal with them. Even in the absence of such an analysis, it is hoped that insurers themselves, given the present stimulus - that is the aim of this article - would consider engaging themselves in examining the spectrum of their risk management tasks.

Identification of risk exposures of insurers:

The word 'Risk' has its origins in the Italian word, *risicare*, which means, "to dare". Risk-taking is about making choices rather than allowing events to unfold on their own. The risk exposures of an insurer can be itemised as:

(1) Corporate governance risks dealing with keeping the stakeholders' interests satisfied, and ensuring management accountability for ethical and strategic performance

(2) Management of 'marketing risks' in dealing with multi-distribution channels for growth

(3) Risks involved in poor customer orientation of staff and their low motivational levels resulting in poor brand image

(4) Fund management risks in improving investment earnings and

(5) Risks in underwriting and claims management that have an impact on the profitability of the insurer.

These risk exposures that are a part of internal environment need to be tackled in the context of the external changes that are imposed on insurers.

The external environment has thrown up risks such as:

(1) Government policy change risks like the increased FDI, disinvestment of capital of public sector companies or mergers among them

(2) Increases in taxes affecting customer demand for products

(3) Detariffing of premium structures leading to market uncertainty

(4) Customer-led risks impacting on the reputation and service standards

(5) Regulatory changes for more accountability, transparency and disclosures by insurers and

(6) Volatility risks in reinsurance markets abroad making reinsurance scarce and expensive.

Managing risk exposures of liberalisation

Though the talk of liberalising the insurance markets was in the air for a number of years, the public sector companies are, even now, substantially unprepared and unadjusted for the competitive changes that have occurred in the market. Equally, the insurers were found unprepared for the entry of brokers and the effect of that on their marketing processes though the legislation to bring them in was debated for a few years. The threats that these changes could pose to their monopoly were neither identified nor measured nor plans implemented to improve their attitudes, internal efficiencies and processes to deal with their consequences. It has been a familiar story of reacting to developments and fire fighting. The only visible response so far has been the implementation of a voluntary retirement scheme for the staff.

Managements of Indian insurers are dealing with the problems of internal environment over which they have more control. The changes taking place in the external environment over which they have little control are left, by and large, unattended; and when they do loom as large, they are dealt with as crises to be handled.

Managements of Indian insurers today, in the exercise of power and authority bestowed on them are spending a lot of their time focusing on dealing with the problems of internal environment over which they have more control. The changes taking place in the external environment over which they have little control are left, by and large, unattended; and when they do loom as large, they are dealt with as crises to be handled.

Globalisation and Government induced competition have changed the external environment faced by insurers. There are now more insurers; more distribution channels; more regulation and more autonomy for public the public sector. What new risks have these changes thrown up? How have the public players responded to this new situation? Have they even grasped the implications of the changes that have come about?

Major changes in the markets

The major changes that have recently occurred in the markets are:

(1) That the monopoly of public players and their marketing arm of Development officers to deal directly with their captive customers has been irretrievably broken by the introduction of private sector companies and other distributors

(2) The de-linking the subsidiaries from the GIC has weakened them in the areas of co-ordination, investment, reinsurance and HRD practices

(3) The fierce private sector competition for profitable segments is another change component

(4) The international reinsurance situation continues to be volatile

(5) The fluctuating stock market is another challenge to manage funds effectively.

These five major changes have significantly altered the landscape of risk exposures of public players in their pursuit for customer acquisition for volumes and profits. They have also imposed on the current managements more onerous leadership responsibilities to lead rather than merely to manage.

Need for an enterprise risk management plan

Insurers need, under the present situation, to prioritise the above risks and the likely changes they will bring about and measure how their probable

occurrence and the degree of their severity would affect their bottom lines for the future. As will be seen from the range of risk exposures stated above, there are several departments involved that deal with them in the process of handling them. There is, therefore, an urgent need for a corporate risk management plan to be conceived, drawn up, debated, approved and implemented with a specified officer responsible for its implementation reporting to the CMD. Banks have taken a lead in the area of risk management due to their implicitly following the international code of rules.

Strategic risk management, unlike traditional risk management, deals with risks as an inevitable part of business environment and does not attempt their elimination; but to adapt to them and improve its risk absorption capability by understanding their ramifications better and deal with them to earn larger rewards. Risk taking has rewards attached to it. Many risks that insurers assume relate to strategy, systems, culture and internal processes over which they have greater control. Managements have the responsibility to keep the 'uncertainty' inherent in the risk to the minimum. Understanding this uncertainty, quantifying it, working out the consequences of it and taking steps to deal with them or control them is what risk management is all about.

While the changes in the external environment and their relative risk exposures can only be anticipated but cannot controlled, it is the responses of the internal environment and its management that will determine how the external threat changes posed can be converted into business opportunities. If the changes and its risks exposures are such that threaten to weaken the insurers' organisations, then insurers have to plan internal environment transformations to meet the external change challenges. In either case it is necessary for insurers to identify the risk exposures in the external changes and put plans into operation to take advantage of the changing scenario.

Managements of insurers have, however, a tendency to deal with immediate problems rather than important ones. For transformational thinking to take place, an external stimulus is needed. It is for the boards of insurers who are responsible to the shareholder and are enjoined to lay down the corporate policy to take the lead in this important area. Should there be a regulation for it?

The serious problems now faced by most public players can be traced to the absence of a enterprise risk management plan that would not only enable insurers to understand better the changing environment and its attendant problems but demand its managements to come up with suitable response mechanisms to deal with them.

The changes in the external environment and their relative risk exposures can only be anticipated but cannot controlled. The responses of the internal environment and its management that will determine how the external threat changes posed can be converted into business opportunities.

What next?

The next urgent issue on the horizon is the imminent detariffing of the Motor Own Damage (OD) business from April 1, 2005. The OD claims ratios of insurers have significantly fallen in 2003-04 resulting in handsome operating profits for insurers. Are the insurers now ready with their corporate risk exposure analysis of how this change, if it should come about, would affect them in terms of competition, growth and profitability and the possible responses of how best one should take advantage of the new development? How will customers react? How will the marketing and administrative staff deal with this change? What are their training needs to absorb this change? How will the competitors deal with it? What strategies will have to be in place in the run up to the change?

Conclusion

The cultivation of a risk management attitude towards their corporate risk exposures, thrown up by the rapid changes in the external and internal environment, is fundamentally important. Such an attitude should lead towards making a careful analysis of how best the insurers can trade risk with opportunity to survive and grow in the increasingly fierce competitive market place.

Where the risks cannot be used as opportunities, but are seen only as threats, having suitable mechanisms in place to deal with them can mitigate their financial consequences. The question to ask is: are insurers ready to change their current corporate attitudes towards dealing with risks that threaten their progress; or alternatively if they can be converted as opportunities for them to grow? If they are not, then it is back to the old days of reacting to changes that might weaken even the current corporate strengths of the insurers to face the future. It will be just too bad if that should happen.

The author is retired CMD, The Oriental Insurance Company.

Analytical Assessment

—Through the Eyes of a Reinsurance Broker

John Thorpe

Reinsurance broking has become less about getting the cheapest cover, and more about managing reinsurance capital in the most efficient way. A good reinsurance intermediary therefore makes significant investment in actuarial and analytical capabilities. The range of services that an international intermediary is expected to provide include detailed loss forecasting, cost allocations, pricing analysis, cash flow analysis and other types of financial modelling. In India Aon Re works closely with Aon Global Insurance Services to provide high value risk management services to Indian direct insurers and GIC.

Clients normally require value creating consultancy services to assist them in

- Making informed reinsurance buying decisions and development in their markets.
- The design, analysis and negotiation of all forms of risk financing programmes.
- The quantification of insurance exposures and the evaluation of risk management strategies.

We have developed (and are continuing to evolve) services, models and products to meet the increasingly complex needs of our demanding client base. Currently, our main skills and objectives include:

- Actuarial and Analytical Assessments – assists with programme design and subsequent placing. Especially useful in hard markets for negotiating cost justified rates.
- Catastrophe Exposure Modelling – enables clients to make more informed decisions regarding retentions, limits and efficient reinsurance pricing.
- Alternative Risk Financing / Transfer – design, analysis and negotiation of 'non-traditional' protections, that combine financing with insurance and risk transfer. This includes access through to capital markets.
- Dynamic Financial Analysis – utilises sophisticated proprietary modelling of assets and liabilities to evaluate optimal reinsurance/risk transfer structure and the financial statement impact given the clients objectives, such as their appetite for volatility/stability or any key ratio criteria.
- Captive Feasibility – consultancy services ranging from the formation of new captives and strategic captive consulting, to the analysis and modelling of the financial impact of captive insurance programmes and the optimisation of capital efficiency.

> A good reinsurance intermediary makes significant investment in actuarial and analytical capabilities.

Actuarial and Analytical Assessment

The assessment and valuation of risk is an integral part of advising our clients and broking any risk transfer or risk-financing product to underwriters, regardless of whether the underwriter is an insurer, reinsurer or capital market investor.

The unit generally takes a stochastic view of the world and has a wide range of statistical tools to carry out the analysis and to develop loss and financial models. We compare and contrast the 'value' of the current reinsurance programme with other options for trading or retaining the risk, based on expected losses and associated volatility, with reference to the company's strategic reinsurance buying objectives. We have developed our own proprietary models where appropriate.

We undertake the following main tasks:

- Reinsurance programme modelling and analytical support for property and liability coverages, including determination of technical pricing having regard to loss exposure periods and market loss probability.
- Risk retention and whole account reinsurance programme analyses.
- Developing proprietary financial statement models that add to the actuarial insight we offer and enable us to assess the effectiveness, based on a company's objectives and constraints, of different reinsurance programmes on the company's profit & loss account and balance sheet. When coupled with investment models we can carry out asset and liability modelling. This is more commonly called Dynamic Financial Analysis (DFA), which allows us to design the most appropriate and optimum risk transferring mechanisms for our clients.
- Benchmarking of Reinsurance programmes across the market. Including comparison of pricing, security, retentions and limits.

Catastrophe Modelling, Financial Analysis and Solutions

We work closely with clients to model catastrophe events against insured exposures. Through reporting the results

of such exposure modelling processes as loss exceeding curves (i.e. the whole probability distribution of potential losses) and superimposing potential reinsurance structures we are able to demonstrate how exposure and volatility by layer affect reinsurance margin loading. We aim to provide information on which management can act. This data can also provide a meaningful point for evaluating the adequacy of primary product pricing.

Aon Re Services Australia, which provides risk management services to all our clients in the Asia Pacific Region, uses the popular RMS, EQE and AIR models as well as other speciality catastrophe models, including Aon Impact Forecasting, for natural catastrophe modelling of worldwide exposures. We have also developed several of our own models for specific regions using advanced software technology to assess the risk clients face from natural and man-made hazards such as subsidence, flood, wind and earthquake.

Alternative Risk Transfer and Risk Financing Solutions and Product Development

The risk trading market has changed dramatically in recent years to include capacity from insurers, reinsurers, commercial banks, swap markets, credit markets and institutional investors. ART has come to mean 'non-traditional' products, which combine financing with insurance and risk transfer, to protect a company from all types of risks, potentially including those that are not normally covered by reinsurance. Through our financial engineering capability we focus on creating solutions that use the most efficient capital sources available. The efficiency of any risk trading and risk financing solution includes the measurement of its ability to meet client objectives. Through the modelling and simulation of cash flows we compare different reinsurance or risk financing strategies to determine the optimal solution that meets the clients objectives, deals with any issues and impacts the balance sheet appropriately.

This incorporates:

- Actuarial, statistical and accounting expertise with in depth experience of financial modelling, financial engineering and premium rating analysis.
- Development, design and negotiation of all forms of Alternative Risk Transfer (ART) solutions, such as blended covers; multi-year multi-line covers; loss portfolio transfers, whole account smoothing protections; finite and financial risk reinsurance; double trigger and integrated risk products (including weather derivatives);

The risk trading market has changed dramatically in recent years to include capacity from insurers, reinsurers, commercial banks, swap markets, credit markets and institutional investors.

  insurance linked securitisation concepts (including contingent equity products such as CatEPuts®).
- Review of the statutory and generally accepted accounting principles, the regulatory, tax and legal objectives and the implications of reinsurance or risk financing transactions.
- Advanced statistical and stochastic techniques to carry our more traditional actuarial services such as capital allocation, capital adequacy reviews, commutations for run-off development and loss portfolio transfers.

Capital Markets Interface

- Aon Global/Aon Re Services work closely with the Aon Capital Markets team in London to identify suitable opportunities for capital markets solutions which include staff who are Securities and Futures Authorities (SFA), registered representatives who can provide advice on products that include the use of derivatives and other forms of financial engineering.

Dynamic Financial Analysis

With new prudential requirements from regulatory authorities in all countries, and the increasingly complex management of insurance, the role of Dynamic Financial Analysis (DFA) is becoming progressively more valuable.

A DFA combines data from the external environment (insurance market conditions, social trends, economic conditions, capital markets) with company specific data (business volumes by type of business, claims experience, asset mix, expense structure, reinsurance arrangements) to represent the insurance company as a single entity. Modelling takes into consideration:

- The random and systemic components of variation inherent in insurance;
- The particular characteristics of each line of business;
- Correlation between years and between lines;
- The Capital base supporting the business;
- Interactions between assets and liabilities;
- Appropriate mix of various classes of assets (equities, bonds, cash, overseas investments, etc); and
- The suitability of various reinsurance programmes

Undertaking DFA of a company can provide insight into its risk profiles and capital management.

Results can include:

- Determination of the key drivers that affect profitability and variability;
- Determination of profitability for different mixes of lines of business;

- An estimate of the optimal asset mix to minimise a measure of risk (such as the probability of solvency) whilst meeting profit requirements; and
- Determination of an appropriate and efficient reinsurance programme given capital and solvency requirements.

Captive consulting

Aon Global/Aon Re Services have access to internal specialists dedicated to co-ordinating the delivery of captive consulting services. This provides a focal point for all captive-related enquiries

The range of strategic captive consulting services provided, include:

- Co-ordination of and assistance with the preparation and delivery of captive feasibility studies and other technical reports.
- Strategic analysis on merging, moving and dissolving captive operations.
- Detailed reviews of all captive quality standards with approved benchmarks.
- Strategic reviews of non-traditional business risks to maximise the captive potential.

A range of actuarial & analytical consulting services are provided:

- Calculation of captive premiums and premium allocation between business units.
- Loss forecasting & risk analysis to determine the expected losses to be incurred by each class or business unit and the variability around the forecast.
- Loss modelling and financial modelling of the captive to determine the cash flows to the captive; reinsurance programme design and for capital adequacy requirements.
- Risk retention analysis to determine the appropriate captive deductible levels on an each and every loss basis and an aggregate basis.
- Benchmarking of captives' loss experience and comparison by business class can also be drawn against industry data where this is available.

The Indian scenario

Following the Gujarat Earthquake in 1999, and in the light of India's vulnerability to growing losses due to natural disasters and escalating fiscal pressures at the central and state levels, the World Bank undertook a detailed review of India's catastrophic exposures. The goal of this project was to examine the loss potentials from natural disasters and to consider the opportunity to apply enhanced country and state level risk management techniques, with a particular emphasis on the financing of post disaster reconstruction and the efficient allocation of public funds.

A recent visit to the Indian insurance companies in the public and private sector revealed that they are now desirous of overcoming the constraints of data collection and collation.

The role of the insurance market was also examined given their major contribution to effective risk transfer of catastrophe risks in other countries but the relatively small role played by insurers in India so far. Among the recommendations made by this study, was to develop models to a greater degree of detail to assess vulnerability more accurately.

The main challenge that had to be faced in developing models to precisely assess the risk for India was the availability of accurate data. But this is changing now. A recent visit to the Indian insurance companies in the public and private sector revealed that they are now desirous of overcoming the constraints of data collection and collation. With the expansion of computerisation, the main hurdle to the creation and maintenance of reliable data on losses has been removed. The time is therefore ripe for the introduction of modelling capabilities for better assessment of catastrophe exposures.

At present there are no models specific to India but the day is not far when all the insurance companies in India actively support and create conditions conducive to the development of catastrophe models for earthquake, typhoons and other natural perils.

In conclusion

Reinsurance programme design and consultancy services of Aon Global (in India) and Aon Re Services (in the Asia Pacific Region) build on the expert knowledge database of Aon Re globally.

The principle advantage of bringing these skills and resources together is to enable Aon Global in India and the Aon Re Services in the Region to provide solutions across the entire risk continuum, based on integrated technical and financial analysis of client risk exposures. This leads to the implementation of products, which combine some, or all of risk transfer, insurance and financing and assists clients in ensuring the most efficient use of their risk capital.

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Life Risk

— Risk Management in Life Insurance

Dr. H. Sadhak

During the last few years, one of the major concerns of regulators, managers and customers in the financial services industry has been that of risk management. The concern for risk management in financial institutions started in 1984, when R. Stucz published his epoch making article "Optional Hedging Policy" in the Journal of Financial and Quantitative Analysis Suggesting 'a viable reason for objective function concavity.'

Since then a number of experts highlighted the concern and rationale for risk management. The concept of risk management in the insurance industry, like banks, mutual funds, pension funds and other financial entities (FEs) has emerged as the most important area of focus, and several initiatives have been taken at the regulatory and enterprise level to identify, measure and manage the risk that are emerging like an epidemic all over the world.

However, in India there is yet to develop the kind of seriousness that observed in the developed markets. It has not attracted required attention either at the regulatory or at the enterprise level. This article is an attempt to briefly discuss the threats of various risks, the tools to measures them and the practices to manage them and suggests a risk management framework for indian life insurance industry.

Risk management is a broad concept encompassing the objectives of risk management, sources of risks, risk management, oversight of implementation of risk policy etc. Though ideally risk elimination would be the key objective of risk management, in reality it is totally impossible to eliminate. Therefore a realistic objective would be to attempt to reduce the intensity of risk, if not total elimination. The central objectives of a risk management policy are to maximise the shareholders value and risk adjusted return and to minimise volatility related to covering.

Sources of risk

Designing any strategy to manage future risks of any organisation need the understanding of the risk and their origin and direction – linked to our environment, which is quite dynamic.

The world changes so fast that neither information systems nor management practices are able to capture the potential trend and the direction of the change. This leads to uncertainty and inability to initiate proactive measures. The major changes that have been noticed are: changes in demographic structure – mortality, life style, killer diseases (like AIDS and SARS) impacting the demographic composition; impact on financial services of rapid globalisation, information explosion and unanticipated volatility in financial markets. These changes have made the Law of Averages, which has been traditionally used by Life Insurance Corporation (LIC) to discount the impact of risks, has become nearly redundant and therefore, there is a search for a new model methodology and management strategies to face the challenges of various types of risks that are being confronted by insurance companies.

> However, in India there is yet to develop the kind of seriousness that is observed in the developed markets.

As we proceed to discuss strategy, let us examine the import types of risks and their sources:

Types of risks

It is virtually impossible to provide a list of risks in life insurance operation basically due to the fact that risks are associated with multidimensional changes associated with the factors mentioned above. However, the major focuses of risks of insurance business are related to macro-economic factors, pricing, claims, credit, spreads, and investment risks which can be classified in two ways: one from the actuarial point of view and the other from the financial market point of view.

Actuarial view of risks are basically classified as:

- **Asset – Liability Risks:** arising from mismatch between assets and liability of an insurance company due to fluctuation in interest rates, inflation causing changes in value of assets and liabilities.
- **Asset Risks:** arising from default of borrowers causing or decline in market value of investment assets.
- **Pricing Risks:** arising from uncertainty in mortality, claims, leakages, management expenses and income from premium, investment and real estate.
- **Miscellaneous Risks:** arising from changes in regulatory regime and requirements, taxation, malpractices at operational level and inefficiency in management practices, lack of accountability and fiduciary responsibility.

Financial view of risks

The actuarial concept of risks as mentioned above can however be broaden and decomposed into six generic types from the financial sector economists view these risks are:

- **Actuarial Risks:** associated with issuance of insurance policies and related liabilities. These risks arise due to higher cost of raising funds, higher underwriting losses than projected etc.
- **Systematic or Mack risks:** associated with asset liability mismatch, arising out of changes in interest rate, inflation etc.
- **Credit Risks:** associated with default of borrowers of funds.
- **Liquidity Risks:** associated with funding crisis arising out of unforeseen demand for funds to meet obligations.
- **Operational Risks:** associated claims processing, settling, record

keeping, risk relating to delivery on trades in exchanges etc.

- **Legal Risks:** associated with financial contracts, frauds, violation of regulation etc.

Measuring Risk

Risk management however, calls for risk identification and risk measures. A number of methods have been in use to measured the risks in an insurance company, though there is no single best measure yet like VaR (Value at Risk) which is widely used for banking industry. Most widely used measures in insurance companies are:

- Actual and Expected Experience Monitoring
- Risk Based Capital (RBC)/Ratios/ Target
- Scenario Analysis
- Stress Testing
- Cash Flow Testing (CFT)
- Cash Flow Matching (CFM)
- Duration and Convexity Analysis
- Performance Attribution/Exchanges by Source

In A/E ratio analysis actual experience to budget plan and pricing is monitored to see to what extent liability assumptions are met. In RBC analysis 'the ratio of RBC to adjusted statutory surplus is used as the standard for surplus adequacy related to risk'. In scenario analysis liabilities and assets of a portfolio is examined under different macro-economic assumption, while stress testing is conducted by using scenario to find out extraordinary losses arising out of a particular widely used to examine the whether asset in matching the liabilities of a portfolio.

Under CFT analysis, basic asset/ liability analyses are undertaken to verify that sufficient reserves are maintained particularly for generated income controls (GICs) and annuity products, while under CFM liabilities are matched with cash flows. There are many other measures to monitor the portfolio risks – and normally a set of measures are simultaneously used by a company. While in convexity analysis the price sensitivity of duration to a change in the interest rate is monitored, in duration analysis price sensitivity of portfolio or security is examined in return to change in interest rates. Performance attribution test is conducted to find out the risk factors causing losses by comparing the actual performance with pre-designed performance.

Risk management practices

Like Risk management methods there are a variety of techniques used by the insurance companies to manage risks. According to Babbel and Santomero of Wharton School, 'it appears that a common practice has evolved such that four elements have become key steps to implementing broad based risk management system.'

> It is necessary to create awareness about the necessity of risk management as well as to develop expertise in this discipline.

- Standards and Reports – setting up underwriting risk classification and review standards and standardisation of financial reporting system.
- Underwriting Authority and Limit – to exercise internal control on managers.
- Investment guidelines and strategies – to exercise control over desired asset liability mismatch.
- Incentive Scheme – to relate compensation to risk and earnings.

Since there is no uniform technique to manage the entire gamut of risks in life insurance company there are several methods and developed practices to manage actuarial risks, through pricing system, solvency margin etc. However, recent developments indicate that 'static assumptions regarding loss distribution failed to manage risks arising out of interest rate volatility. Another risk factor is the incentives to agents and marketing staff which encourages them to sell more new policies, replace old polices, and all these increase the overall risks for the company.

In the areas of systematic risks, top on the list of risk management technique is the Asset Liability Management (ALM) because it not only covers interest rate volatility but also non-interest risks arising out of embed options in the policy. Further, ALM is used to manage product specific risks as well as company wide risks.

A survey of global consulting firm, Milliman USA, of Risk Management Practices of US Life Insurance companies shows that more than 75 per cent of the companies indicated that they use the following Risk Management practices :

- Risk Insurance
- Diversification of Assets
- Diversification of Liabilities
- Selective underwriting
- Continual Process Improvement
- Hedging via Capital Market
- Stochastic Pricing
- Risk Adjusted Pricing Targets

Risk limits set the maximum exposure to risk factors and risk tolerance of the Management. Reinsurance allows risk transfer to another party through an reinsurance agreement. Diversification of assets minimises the impact of unsystematic risks on the portfolio while diversification of liabilities is achieved by offering diverse products. Hedging in capital markets is aimed at reducing the adverse impact of interest rate fluctuation achieved through derivatives, futures, forward trading, options and swaps.

It may be mentioned here that insurance supervision, to strengthen the

risk management practices, focuses more and more on the capital of an insurance company against the bench mark of assured risks in addition to the statutory solvency margin. In the US, the risk based capital laws now in effect in all states require commissioners to take specified actions when a firms' risk based capital ratio, defined as the ratio of actual ratio to risk based capital, falls below a certain threshold (Cumming, Philips and Smith 1997). Even in Europe, the solvency project is centred around the risk based capital model: In a capital based solvency system, risk bearing business will be linked to more risk capital.

Risk management scenario in India

So far in India, very scanty attention has been given to risk management in insurance companies. Neither is any systematic and structured risk management practice followed in insurance companies nor have any specific guidelines on risk standards, techniques and risk management been developed. Of course IRDA guidelines on Investment Management and Asset, Liabilities and Solvency margin of insurers indirectly deal with Risk Management. The risk management prevailing in Indian companies is of a very rudimentary type. Indian financial markets, particularly during the post liberalised era have witnessed significant understanding. Global intervention, changes in interest rate regime etc. have increased the risk exposure. It is therefore necessary to create awareness about the necessity of risk management as well as to develop expertise in this discipline.

However, risk management practices can be successfully implemented through institutionalisation of the risk management culture and creating a necessity for adopting it. Management may also consider introducing certain incentives and disincentives – incentives for maximising policyholders' return through risk management and disincentives for non-implementation of risk management which adversely affect asset value and policyholders' benefits. Risk management has its cost also and they include the cost of professional training, technology, time and short term losses due to rigid implementation of risk policies. However managements should be willing to bear this cost in their own long term interest.

In view of the poor state of the risk management practices in India, the following steps are urgently required.

Risk standards

A uniform practice of risk management needs to be introduced through the life insurance industry. This calls for introduction of Insurance Industry Risk Standard (IIRS) incorporating the entire gamut of risk management and risk oversight. Risk Management must include the fiduciary responsibility of board and managers, risk management objectives, responsibilities of various entities, checks and balances, independent risk oversights. For these, there is need for adequate education and training which also may preferably be uniform industry wide.

> Independent review of risk management practices and risk measurements are required at frequent interval by the primary fiduciary and manager fiduciary.

Oversight

Independent review of risk management practices and risk measurements are required at frequent interval by the primary fiduciary and manager fiduciary. This review should include analysing policy compliance, due diligence, monitoring investment guidelines, investment strategies, risk limits, evaluation of investment models. If required, revision redesigning of models, strategies, risk limits may be done within the overall guidelines and parameters of the regulator.

Institutionalising Risk Management

Risk management practices can be institutionalised by separating Risk Monitoring (RM) from operational functions. Monitoring should be entrusted to the entity not involved in operational matters. Though implementation will be reviewed by the primary fiduciary like board, top management, yet there is a necessity for independent monitoring through designated person. Many organisations appoint a Chief Risk Officer (CRO) who is a reasonably senior level executive reporting to the chief executive of the organisation. However, for better coordination and monitoring a risk management committee (RMC) can be set up, which would be assisted by the CRO. RMC would be a high power committee report directly to the board on quarterly basis. RMC would monitor implementation of Risk Standard, Risk Limit, ALM, measures, analyse investment strategy in relation to portfolio objectives and predetermine risk limits.

Risk Governance

The risk management system to protect assets from depletion may be made stronger through implementation of risk governance. Risk governance can be established either through 'risk control' or through 'risk reward'. In either of these models, there is a necessity for improving risk knowledge, risk information and competitive risk practices. Genuine risk reporting and starting of risk information will strengthen risk governance. However, the goal of risk governance can be achieved if the top management and board are truly interested and sincere.

Risk management should not be thought and the regulatory requirement, but an integral part of strategy and way of corporate life.

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प्रकाशक का संदेश

बीमा से तात्पर्य जोखिम का मूल्यांकन तथा उपयुक्त प्रक्रिया द्वारा उपाय खोजना है, जिससे जोखिम को आवरण प्रदान किया जा सके। जैसा कि किसी भी उद्योग में होता है, वह अपने ही जोखिम को झेलते हैं, अन्य से मिलता जुलता तथा बहुत सारा, बिल्कुल अपूर्व। बीमा उद्योग में जोखिम प्रबन्ध जिस पर हम आईआरडीए के इस अंक में ष्टिपात करेगें। पारदर्शिता तथा अनुवर्तन शासन के मजबूत सिद्धान्त हैं तथा जोखिम प्रबन्ध की कुंजी हैं।

उद्योग के लिए निगमित शासन कसौटी बनाने हेतु प्राधिकरण प्रक्रियाबद्ध है साथ-साथ उद्योग के अलग अलग बाजी लगाये हुए लोगो को प्रोहत्साहन दिया जा रहा है। जीवन तथा गैर-जीवन बीमा कंपनियों की ही तरह ब्रोकर, सर्वेयर - को बनाना होगा अथवा फ़ोरम को प्रेरक के रूप में स्वयं विनियमित संगठन के रूप में कार्य करना होगा। केन्द्रीय विनिमयन से स्वयं विनियमन का परिवर्तन ग्लोबल झुकाव है, जहाँ अच्छे बाजार के लिए आचरण व्यवसायियों द्वारा स्वंय ही बाजार अनुशासन और पर्यवेक्षण द्वारा निर्धारित किया जाता है।

उच्च मानक स्थापित करने तथा उनका पोषण करने के लिए विनियमन के स्तर पर संयुक्त प्रयास अधिक उत्पादक साबित होगे। इसके पीछे प्रबल कारण है। वित्तीय क्षेत्र के सभी व्यवसायी न केवल लेनदेन के आधार पर वरन् ष्टिकोण के आधार पर भी एक ष्टिगोचर होते हैं। एक कंपनी में हुआ संकट ग्राहको के बीच सभी कंपनियों के बारे गंभीर आशंका फैलाता है तथा उसका असर दिल दहला देने वाला होता है। उद्योग के सदस्यों ने यह अनुभव किया है कि उनकी मजबूती सबसे कमजोर कड़ी पर निर्भर करती है तथा उद्योग के सदस्यों का संयुक्त विवेक उन्हें उस कड़ी से सुरक्षा दिलवायेगा। वह कमजोर कड़ी जो सरलता से सबको डूबकी लगवाने मे सक्षम है।

अगला अंक उन क्षेत्रों की खोज करेगा, जहाँ प्राधिकरण तीव्रता से विकास देखना चाहती है। हेल्थ बीमा, हेल्थ केयर प्रणाली उपलब्ध करवाने वालो के क्षेत्र में सुधारों से संबद्व है। उस क्षेत्र उनके सुधार बीमा क्षेत्र के हाथ में नही है, हमें यह देखना होगा कि उपलब्ध करवाने वालों के क्षेत्राधिकार में सुधार हुए बिना देरी किये क्या किया जा सकता है। जनसंख्या के उस वर्ग के लिए जो प्रिमियम दे सकता है तथा वह उपचार की लागत को झेल नहीं सकता है, के लिए विकास का केन्द्र बिन्दु हेल्थ बीमा होगा। वैसे जनसंख्या का कुछ भाग ऐसा भी है जो परिमित प्रीमियम भी नहीं दे सकता। इनकी मदद के लिए कौन से हस्तक्षेप की जरूरत है? हम ऐसी बीमा सुरक्षा कैसे बना सकते है जो हैल्थ सेवाओं की लागत को न बढाये। इन बडे मामलों की यहाँ चिंता है तथा हम आगे नवोन्मेष विचार देखना चाहेगे जो इन चिंताओं को संबोधित कर सकें।

सी. एस. राव

“ कुछ तो लोग कहेंगे ”

आज से 10 वर्ष आगे देखते हुए, मेरा यह दृढ़ विश्वास है कि परम सफल, न्यूनतम संकटग्रस्त व्यवसाय वह होगा जिसमें बोर्ड ने ढ़ संकल्प लिया है तथा निर्णयपूर्ण कार्रवाई की है। वास्तविक, अविभाज्य, कार्यनीति जिसे कल व्यवहार का जोखिम तय करना है, के लिए अवश्यकता अभी बोर्ड स्तर पर संस्कृति में परिवर्तन करने की है।

लार्ड पीटर लेविन, अध्यक्ष लायर्ड आफ लंदन

हेल्थ बीमा क्षेत्र में प्रगति बिल्कुल असंतोष जनक है।

श्री टी. के. बैनर्जी, सदस्य (जीवन) आईआरडीए

वेब एक समग्र क्षमता संचार चैनल का प्रतिनिधित्व करता है। यह आश्चर्य की बात है कि बहुत कम वाहक इस सुविधा का सफलतापूर्वक संप्रवर्तन अपने ग्राहको की सेवा के लिए कर रहे है। बीमा वाहक जो नये, नवोदित खरीदार, की जरूरत है, उन्हे वेब संचार चैनल से अपने को एकीकृत करना चाहिये।

श्री जेरीमय बाउलर, निदेशक, बीमा व्यावहार, जे.डी. पावर व एसोसिएट एक यूएस अध्ययन के बारे में, जिसमें कारों के नवोदित क्रयकर्त्ता इंटरनेट से खरीददारी में नयी जान फूंक रहं हैं।

कुछ संख्या में आवरण अंतराल का विस्तारण हो रहा है जबकि जोखिम का स्थानांतरण व्यक्तिगत रूप से हो रहा है। आगे यह केवल तभी बढेगा जब ज्यादातर राष्ट्र अपनी लडाई जनसंख्या की उच्च दर से कर सकेगें। परंपरागत उत्पाद परंपरागत एजेंट चैनल से बेचे जाते है तथा वह व्यापक बाजार के लिए काफी हो गये है

श्री माईक कोस्टोफ, कार्यकारी निदेशक, निगमित कार्यकारी बोर्ड वित्तीय सेवाओं का अध्ययन व्यापक बीमा बाजार की लाभप्रदता के बारे में।

क्योकि यह तेजी से बढ़नेवाला उद्योग है, बहुत से लोग इस दौड में शामिल होना चाहते हैं। लेकिन वर्ष के अन्त तक हौसला नहीं बनाये रख पाते।

श्री शिवाजी डाम, प्रबन्ध निदेशक, कोटक लाईफ इंशुरेन्स, उद्योग में उच्च आकर्षक दरें जिनके बारे में सूचना है कि यह 14 से 38 प्रतिशत तक है।

हमने ऐथेंस पोर्ट का सुरक्षा विश्लेषण निरवधि के छः से सात महीने पहले कर लिया था। वह सैकडों संस्तुतियों के साथ आये, क्योकि उनके आगमन से पहले कोई सुरक्षा नहीं थी।

क बीमालेखनकर्त्ता ऐथेंस ओलंपिक को बीमा सुरक्षा उपलब्ध करवाने हेतु टिप्पणी करते हुए। जिसने एक बिलियन डालर का बीमा करवा कर पिछले रिकार्ड तोड दिये।

बढ़ती ग्राहक अपेक्षा प्रवृत्ति

अभिजीत चटर्जी

भारत में बीमा क्षेत्र के उदारीकरण के पीछे मुख्य उद्देश्य उपभोक्ता को उपलब्ध सेवा और विकल्प का विकास करना था। इसे अभी केवल तीन वर्ष हुये हैं और उपभोक्ता आज निश्चित रूप से शीर्ष पर है। बीमा बाज़ार विक्रेता बाज़ार से क्रेता बाज़ार में परिवर्तित हो गया है। 14 जीवन बीमा तथा 13 ग़ैर-जीवन बीमा कंपनियों द्वारा प्रस्तुत उत्पादों की भीड़ ने उपभोक्ताओं को न केवल व्यापक विकल्प प्रदान किया है, बल्कि इसके परिणामस्वरूप पिछले तीन वर्षों में उपभोक्ता अपेक्षाओं में तीव्र वृद्धि भी हुई है। बीमा उत्पादों की व्यूह रचना का सामना करने वाला ग्राहक अब अपनी पॉलिसी की तत्काल सुपुर्दगी, व्यक्तिगत ध्यान, कस्टमाईस्ड प्रस्ताव, उनकी पॉलिसी के संबंध में सुगमता से जानकारी, भुगतान तंत्र की बहुलता, उनकी शिकायतों पर तत्काल प्रभाव आदि के अलावा और बहुत कुछ चाहता है। विशेष बात यह है कि ग्राहक यह सेवाएं बिना किसी अतिरिक्त भुगतान के मांग रहा है।

बीमा कंपनियां बढ़ी हुई अपेक्षाओं से किस तरह निपट रही हैं?

इस वातावरण, जिसमें ग्राहक की संतुष्टि वित्तीय सेवा क्षेत्र में विकास करने के लिये प्राथमिक बाध्यताओं में से एक है और जहां व्यक्तिगत उत्पादों की आसानी से प्रतिकृति कर ली जाती है, में सेवा की गुणवत्ता ही विभिन्न सेवा प्रदाताओं के बीच मुख्य विभेदक है। इसलिए, बढ़ती ग्राहक अपेक्षाओं को पूरा करने के लिये बीमा कंपनियों के लिये यह आवश्यक हो गया है कि वह उत्पादों व सेवाओं का लगातार पुनर्रूपांकन करें।

भारत में बीमा उद्योग उत्पादों की स्थूल श्रृंखला को 'एक-नाप-सभी को-उपयुक्त' की तरह ग्राहकों की एक भारी संख्या को बेचने की प्रवृत्ति से आज स्पष्ट रूप से दूर हो रहा है। विभिन्न उत्पाद दिशाओं (जैसे, जीवन, संपत्ति और मरण आदि) को गोदाम की तरह उभारने के बजाय बीमा कंपनियां उच्चतम लक्ष्य वाले बीमा उत्पादों के रास्तों की तलाश में हैं, जो व्यक्तिगत ग्राहक के लिए एकदम उपयुक्त हों और साथ ही जिनमें उन्हें खरीदने की उच्चतम प्रवृत्ति हो। बीमा कंपनियां ग्राहकों के उभारे गये अंशों की पूर्ति के लिये विशिष्ट उत्पादों का रूपांकन कर रही हैं।

यह निर्विवाद है कि आज के परिश्य में बीमा क्षेत्र में बिक्री की बढ़त एजेंसी बल के माध्यम से चालित है। ग्राहक के मन पर एक बीमा कंपनी के बारे में जो पहला सूचित प्रभाव पड़ता है, उसके लिये एक एजेंट व्यापक रूप से जिम्मेदार होता है। एक पुरानी उक्ति है -''पहला प्रभाव आखिरी प्रभाव होता है।'' यद्दपि हम सभी को यह पूरी तरह नहीं स्वीकार कर लेना चाहिए, क्योंकि मैं निश्चित नहीं कह रहा हूं, लेकिन यह सर्वविदित और मान्य है कि उच्च प्रशिक्षित और उत्पादक एजेंसी बल ग्राहकों को उचित स्तर की सेवा प्रदान करने के लिये एक आवश्यक (हालांकि पर्याप्त नहीं) शर्त है। उपर्युक्त पृष्ठभूमि के अनुसार बीमा कंपनियां अपने एजेंटों के लिये कड़ा प्रशिक्षण कार्यक्रम चला रही हैं, इनमें से अधिकतर कंपनियां आईआरडीए द्वारा 100 घंटे के अधिदेशित प्रशिक्षण कार्यक्रम से अधिक प्रशिक्षण दे रही हैं।

एक कमजोर पक्ष दावों के निपटारे में लिया जाना वाला समय है, बीमा क्षेत्र की शुरूआत से उपभोक्ताओं को भयावह तरीके से लाभान्वित किया जाता है। आज दावों को निपटाने की औसत समयावधि को 50 से 60 दिन तक से घटकर 10 से 15 दिन तक आ गई है। ग्राहक बीमा पॉलिसियों के दस्तावेज़ीकरण में उच्च कोटि की स्पष्टता और पारदर्शिता से भी लाभान्वित हुये हैं।

उपभोक्ताओं की रुचि तथा बदलती प्राथमिकताओं के अनुसार चलने के लिये भारत में अधिकतर बीमा कंपनियां उन्नत सीआरएम टूल्स को अपना रही हैं, जो उन्हें ग्राहकों की गतिविधि का अनुवीक्षण करने में मदद कर रहे हैं। यह सीएमआर टूल्स कंपनियों को अपने ग्राहकों के बारे में विवरण प्राप्त करने, अच्छे उत्पादों की अभिकल्पना करने, सेवा का विकास करने तथा प्रचालन लागत कम करने की मंजूरी देते हैं।

नियमनों की भूमिका

बीमा क्षेत्र में भविष्य के नियमन जो रास्ता तय करेंगे, वह ग्राहकों की बढ़ती अपेक्षाओं को पूरा करने की बीमा कंपनी की योग्यता पर महत्वपूर्ण रूप से प्रतिभूत रहेंगे। उपभोक्ताओं के हित में जिन तीन मुख्य कानूनों/नियमनों में परिवर्तित किये जाने की आवश्यकता है, वह नीचे रेखांकित किये जा रहे हैं।

1) भारतीय बीमा बाज़ार में एजेंसी बल द्वारा निभाई गई विशिष्ट भूमिका को ऊपर रेखांकित किया जा चुका है। फिर भी एजेंट की वर्तमान कमीशन दरों पर लगी सीमा इस व्यापार में उत्कृष्ट प्रतिभा को आकर्षित करने की बीमा कंपनियों की योग्यता को गंभीर रूप से पंगु बना रही हैं। इस क्षेत्र में कुछ व्यावसायिकों को छोड़ अधिकतर एजेंसी बलों में आज अंशकालिक लोग हैं। बीमा कंपनियों को पूर्णकालिक व्यावसायिकों की भर्ती करने के योग्य बनाने के लिये बीमा अधिनियम 1938 की धारा 40अ से 44 तक के अंतर्गत एजेंट क्षतिपूर्ति से संबद्ध कानूनों व नियमनों में संशोधन करने की आवश्यकता है। कंपनियों को दिये गये दिशानिर्देशों के समग्र ढांचे के भीतर एजेंटों के लिये क्षतिपूर्ति योजनाओं की अभिकल्पना करने की स्वतंत्रता दिये जाने की आवश्यकता है। एजेंसी बल की निम्न गुणवत्ता अंतत: निम्न स्तर की सेवा के रूप में प्रतिफलित होती है, जो उपभोक्ता द्वारा प्राप्त की जाती है।

2) पूरे विश्व में बीमा पॉलिसियों की बिक्री और बीमा बाज़ार के विकास में राइडर्स ने उल्लेखनीय योगदान किया है। वर्तमान में भारत में राइडर्स पर तीस प्रतिशत की सीमा है। ग्राहकों को नियमित सेवाएं उपलब्ध कराने के लिये बीमा कंपनी की योग्यता में वृद्धि करने के क्रम में नये उत्पादों की संख्या की सीमा को हटाने की आवश्यकता है, इन उत्पादों को राइडर्स पर लगी 30 प्रतिशत की सीमा को हटाकर उपभोक्ताओं को उपलब्ध कराया जा सकता है। जैसा कि पहले कहा जा चुका है, विश्वभर में यह साबित हो चुका है कि बीमा उत्पादों की बिक्री बढ़ाने में राइडर्स एक प्रभावी साधन हैं। भारत में बीमा कंपनियों को भी इसी तरह के आदर्श को अपनाने की आवश्यकता है।

3) उत्पादों के मूल्य निर्धारण के विषय में कुछ समय से बहस हो रही है, विशेषकर साधारण बीमा व्यापार में। उदारीकृत बीमा बाज़ार में दर सूचियां पूर्ववर्ती रही हैं। जब तक सभी ग़ैर-जीवन बीमा उत्पादों के मूल्य निर्धारण में स्वस्थ प्रतियोगिता नहीं होती, तब तक बीमा कंपनियां उपभोक्ताओं को उदारीकरण के सभी वास्तविक लाभ पहुंचाने में सफल नहीं होंगी।

बीमा उद्योग में सावधानी की ऐसी तीन बातें हैं, जो जोखिमधारकों को अपने मस्तिष्क में रखने की आवश्यकता है।

पहली बात, एक अरब से अधिक जनसंख्या वाले देश में ग्राहकों की बढ़ी हुई अपेक्षा, जिसकी हम बात कर रहे हैं, जनसंख्या के एक वृहद हिस्से में आ गई है। इसलिये देश के उप-नगरीय तथा ग्रामीण क्षेत्रों को प्रभावी रूप से लक्ष्य बनाते हुये बीमा की कुशलता बढ़ाने की शीघ्र आवश्यकता है। इसलिये ऐसा करने के लिये वितरण माध्यमों, विशेषकर बैंक आश्वासन तथा आढ़तियों (दलालों) का प्रभावी रूप से इस्तेमाल किये जाने की आवश्यकता है।

दूसरी बात, पिछले तीन वर्षों में पॉलिसीधारकों के लाभों के प्रकटीकरण के संबंध में पारदर्शिता लाने में प्रगति हुई है, लेकिन अभी भी बहुत कुछ किया जाना बाकी है। बहुत से देशों में तुच्छ बिक्री प्रयासों तथा प्रकटीकरण के अभाव के संबंध में ग्राहकों के कानूनी मुकदमों के कारण बीमा कंपनियों पर उल्लेखनीय जुर्माना हुआ है। भारत में ऐसी घटनाओं की पुनरावृत्ति को रोकने के लिये कदम उठाने की आवश्यकता है।

तीसरी और सबसे महत्वपूर्ण बात, 'ग्राहकों की अपेक्षाओं में वृद्धि' आवश्यक रूप से इसका समानार्थक नहीं है कि 'ग्राहकों की जागरूकता बढ़ी' है। भ्रामक सूचना और उपेक्षा पर आधारित ग्राहकों की अपेक्षाएं उद्योग की धारणीय संवृद्धि के लिये घातक हो सकती हैं। उद्योग को भारत में लोगों में जागरूकता का स्तर बढ़ाने के लिये बीमा क्षेत्र में अन्य जोखिमधारकों के साथ मिलकर काम करने की जरूरत है।

लेखक भारतीय उद्योग महासंघ से संबद्ध हैं.

नये माध्यम, नई चुनौतियां

रश्मि अबिचंदानी

बीमा उत्पादों का विपणन अधिक से अधिक महत्वपूर्ण होता जा रहा है और इसलिये विपणन के वैकल्पिक माध्यम भी महत्वपूर्ण होते जा रहे हैं। शहरी क्षेत्रों यह इंटरनेट, आटोमेटेड टेलर मशीन (एटीएम), काल सेंटर, सीधे डाक आदि को शामिल कर सकता है। ग्रामीण क्षेत्रों में हम माइक्रोफ़ाइनांस संस्थानों तथा एनजीओ पर निर्भर हैं। यह सभी माध्यम मूल रूप से डेटाबेस विपणन को अंतर्भूत करते हैं, यह डेटाबेस (आधारभूत आँकड़े) वित्तीय संस्थानों/कंपनियों या अन्य सेवा संगठनों द्वारा साधारणत: उनके स्वयं के उपयोग के लिये अपने ग्राहकों से सूचनाएं एकत्र कर तैयार किया जाता हैं। उदाहरण के लिये बैंक अपने ग्राहकों के बारे में सूचनाएं एकत्र करते हैं।

तकनीकी में हुई प्रगति ने भी व्यक्तिगत गोपनीयता, विशेषकर उनकी निजी सूचना के अहस्तांतरणीयता मूल्य को गंभीर चुनौती देना प्रारंभ कर दिया है। कंप्यूटर तकनीक और डेटा संग्रहण तकनीक में हुई प्रगति ने लोगों और निजी संगठनों को ग्राहकों के बारे में व्यापक सूचना संग्रहित करना संभव कर दिया है। इस सूचना में वे कौन हैं, वे कहां रहते हैं, वे कितना कमाते हैं और अपना पैसा किस तरह ख़र्च करते हैं आदि सूचनाएं शामिल होती हैं। यह सूचना (ग्राहक डेटाबेस) कई बार ऐसी कंपनियों से संबद्ध कंपनियों को दी जाती है या अन्य कंपनियों को बेची/बांटी जाती है। वैज्ञानिक तथा तकनीकी सहयोग बढ़ने के कारण भी डेटा संग्रहण में अपार वृद्धि हुई है। इसलिये प्रश्न यह है कि ग्राहक की पूर्व सहमति/सूचना के बिना क्या सूचना का ऐसा आदान-प्रदान किसी व्यक्ति की गोपनीयता के अधिकार का उल्लंघन होगा?

सदियों से गोपनीयता मानव मूल्य समझी गई है। गोपनीयता कानून न्यायिक प्रख्यापन के माध्यम से काफ़ी विकसित हुआ। विनिर्दिष्ट संवैधानिक अभिज्ञान के अभाव के बावजूद मानवाधिकारों पर अंतर्राष्ट्रीय दस्तावेज़ों में गोपनीयता के अधिकार ने काफ़ी विस्तृत स्थान पाया है, जैसे कि मानवाधिकार के वैश्विक घोषणा-पत्र का अनुच्छेद 12, नागरिक एवं राजनैतिक अधिकार पर अंतर्राष्ट्रीय प्रसंविदा, 1966 (जिसमें भारत एक हस्ताक्षरकर्ता है) का अनुच्छेद 17 तथा मानवाधिकारों पर यूरोपीय सम्मेलन का अनुच्छेद 17.

विश्व के कई अन्य भागों में स्थित अधिकार क्षेत्र की तरह भारत का संविधान गोपनीयता के अधिकार को मूलभूत अधिकार के रूप में संस्तुति नहीं देता। फिर भी 1964 में उच्चतम न्यायालय ने संस्तुति दी कि गोपनीयता का अधिकार संविधान के अनुच्छेद 21 के अंतर्गत निहित है। यह कहता है -'विधि के द्वारा स्थापित प्रक्रिया को छोड़ किसी भी व्यक्ति को उसके जीवन या व्यक्तिगत स्वतंत्रता से वंचित नहीं किया जाएगा।'

गोपनीयता पर कानून विकसित करने के अवसर के साथ भारतीय उच्चतम न्यायालय में सबसे पहले कुछ जो मामले प्रस्तुत किये गये, वो पुलिस निगरानी के थे। न्यायालय ने उन विधानों की संवैधानिक वैधता का परीक्षण किया, जो पुलिस को किसी व्यक्ति पर गुप्त रूप से निगरानी रखने का अधिकार देते हैं। इस तरह का पहला मामला खड़क सिंह बनाम उत्तर प्रदेश राज्य था। निगरानी के एक अन्य मामले - गोबिंद बनाम मध्य प्रदेश राज्य - में उच्चतम न्यायालय ने गोपनीयता के एक सीमित अधिकार को संस्तुति दी। फिर भी न्यायालय खड़क सिंह फ़ैसलै से आगे गया और लागू नियम, जो अपने पूर्ण रूप में आवास पर जाने का अधिकार देता है, का समर्थन किया। यह इस आधार पर है कि प्रावधान का उद्देश्य अपराध को रोकना है।

गोपनीयता के भारतीय कानून के विकास में आर. राजगोपाल बनाम तमिलनाडु राज्य एक महत्वपूर्ण मोड़ साबित हुआ। पहली बार उच्चतम न्यायालय ने प्रेस की स्वतंत्रता के परिश्य में गोपनीयता के अधिकार पर चर्चा की।

यह मामला सज़ायाफ़्ता क़ैदी 'आटो शंकर' की आत्मकथा प्रकाशित करने के पत्रिका के प्रकाशक के अधिकार से संबंधित था। प्रतिवादियों ने दलील दी कि प्रकाशित की जाने वाली सामग्री (जिसमें पुलिस अधिकारियों और अपराधियों के बीच कुछ सनसनीख़ेज संबंधों का खुलासा किया गया है) से अवमानना हो सकती है तथा इसलिये इस पर रोक लगाने की आवश्यकता है। इस परिश्य में गोपनीयता के अधिकार का मामला उभरा। उच्चतम न्यायालय ने यह निर्णय दिया कि प्रेस को आटो शंकर की आत्मकथा के सार्वजनिक रिकार्डों को उसकी सहमति के बिना प्रकाशित करने का अधिकार है। यद्यपि, यदि प्रेस सामग्री सार्वजनिक रिकार्ड से आगे बढ़ती है और उसकी जीवन कहानी प्रकाशित करती है, तो वह उसकी गोपनीयता के अधिकार का अतिक्रमण होगा। इसी तरह सरकार एवं कारागार अधिकारी, जिन्होंने उन्हें संभावित मानहानि (प्रत्यक्ष रूप से दंडित क़ैदी की गोपनीयता की सुरक्षा करने का आग्रह करते हुये) से बचाने की अपील की है, को आत्मकथा के प्रकाशन पर पूर्व रोक लगाने का अधिकार नहीं है। यदि उनकी कोई आपत्ति है तो वह प्रकाशन के बाद ही आएगी।

हाल ही में विभिन्न तरह के मामलों में गोपनीयता-संबद्ध मामले उभरे हैं। ऐसे मामलों में आत्मकथात्मक फ़िल्म, टेलीफ़ोन टैपिंग से लेकर किसी एचआईवी ग्रस्त व्यक्ति की गोपनीयता के अधिकार तक शामिल हैं। हम कह सकते हैं कि गोपनीयता व्यापक रूप से निम्नलिखित को शामिल करती है :-

शारीरिक गोपनीयता : यह आक्रामक प्रक्रियाओं, जैसे जेनेटिक परीक्षणों, दवा परीक्षणों, केविटी खोजों से लोगों द्वारा खुद की शारीरिक रक्षा करने से संबंधित है।

संचार एवं सूचना की गोपनीयता : यह डाक, टेलीफ़ोन, ई-मेल तथा संचार के अन्य रूपों की सुरक्षा तथा गोपनीयता को सम्मिलित करती है। सूचना के संबंध में यह नियमों की स्थापना, जो व्यक्तिगत डेटा जैसे ऋण सूचना, चिकित्सा रिकार्डों और सरकारी रिकार्डों को संग्रहित तथा देखरेख करने को नियंत्रित करती है, को शामिल करती है। इसे 'डेटा सुरक्षा' के नाम से भी जाना जाता है। और अंतिम (लेकिन छोटा नहीं) है

प्रादेशिक गोपनीयता : यह घरेलू तथा अन्य वातारवरणों, जैसे कार्यस्थल या सार्वजनिक स्थल में घुसपैठ, जिसमें तलाशी, वीडियो निगरानी तथा पहचान जांच शामिल है, की सीमाओं से संबंधित है।

यूरोपीय यूनियन (ईयू) ने व्यक्तिगत सूचना तैयार करने तथा ऐसी सूचना के मुक्त परिचालन के संबंध में व्यक्तियों के सुरक्षा पर दिशानिर्देश जारी किये हैं। यह दिशानिर्देश ऐसे देशों को ऐसी सूचना देने से रोकते हैं, जिनके पास गोपनीयता पर कानून नहीं है। इसके अलावा यह दिशानिर्देश यूरोपीय यूनियन के सदस्य राज्यों को वह नियम बताने को कहते हैं, जिसके अंतर्गत ग्राहक सूचना तीसरे पक्ष के साथ बांटी जाएगी।

इसी तरह हाँगकाँग में सूचना की अध्यादेश संबंधी गोपनीयता है। उसमें बताये गये सिद्धांत व्यक्तिगत डेटा का उपयोग उपलब्ध कराते हैं तथा यह स्पष्ट कहते हैं कि यदि डेटा का विषय अनुमति नहीं देता है तो व्यक्तिगत डेटा को उसी उद्देश्य के लिये या सीधे संबंधित उद्देश्यों के लिये उपयोग में लाया जाना चाहिये, जिसके लिये उन्हें संग्रहित किया गया है।

हालांकि अमेरिका में व्यापार उद्देश्यों के लिये गोपनीयता मानक राज्य कानून से संबंधित मामला है, फिर भी फ़ेयर क्रेडिट रिपोर्टिंग ऐक्ट (एफ़सीआरए) तथा ग्रेम-ब्रीच-ब्लीले ऐक्ट (जीबीएलए) का तात्पर्य है कि संघीय कानून साधारणत: ग्राहक ऋण सूचना को नियंत्रित करता है तथा विभिन्न वित्तीय संस्थानों द्वारा एकत्रित ग़ैर-सार्वजनिक व्यक्तिगत सूचना को उजागर करने से रोकता है और उसकी रक्षा करता है। यदि डेटा विषय को सार्वजनिक करने का अवसर नहीं दिया गया है तो जीबीएलए ग्राहक सूचना के आदान-प्रदान पर प्रतिबंध लगाता है, फिर भी यह संबद्ध कंपनियों के बीच सूचना के आदान-प्रदान को प्रतिबंधित नहीं करता। एफ़सीआरए में संबद्ध कंपनियों के बीच सूचना के व्यापक आदान-प्रदान का प्रावधान है, लेकिन इसमें कहा गया है कि ग्राहकों के पास ऐसे आदान-प्रदान से बाहर रहने का प्रावधान होना चाहिए तथा एक जनवरी, 2004 के बाद राज्य इस प्रावधान को अतिक्रमित करते हुये कानून बना सकते हैं।

इसलिये संशोधित जीबीएलए के अंतर्गत राज्य बीमा विनियामकों को कानून में उपलब्ध कराई गई प्रसंविदा से अधिक कड़े मानक अपनाने की छूट दी गई है। यह असाधारण है, क्योंकि साधारणत: अमेरिका में संघीय कानून कड़ी राज्य कार्रवाई को पूर्व अधिकृत कर सकता है। फिर भी बीमा कंपनियों ने एमएआईसी पर दबाव डाला कि वह समान मानकों, जो संघीय कानून के अंतर्गत स्थित मानकों से अधिक कड़े न हों को अपनाने के लिये प्रोत्साहित करे। इस परिश्य में अधिकतर राज्यों ने स्वास्थ्य बीमा सूचना के लिये कड़ी सुरक्षा चाहते हुये उसका समर्थन किया, जो बीमा कंपनियां चाहती हैं।

बीमा ग्राहक अन्य बीमा सूचना के लिये ग़ैर-संबद्ध कंपनियों के बीच किए जाने वाले वित्तीय सूचना के आदान-प्रदान की अनुमति देने से इनकार कर सकते हैं, लेकिन उन्हें कंपनी को यह सूचित करना होगा कि वह उसका आदान-प्रदान नहीं करने देना चाहते। अगर उन्होंने इस संदर्भ में कोई कदम नहीं उठाया तो सूचना का आदान-प्रदान किया जा सकता है। हालांकि सूचना के आदान-प्रदान से इनकार करने के लिये वार्षिक नोटिस दी जाती है, लेकिन अधिकतर ग्राहक इसकी अनदेखी करते हैं, इसलिये कुछ ग्राहक ही इनकार कर पाते हैं।

कइयों ने 'ऑप्ट-इन' पद्धति की वकालत की है। इसमें यदि ग्राहक इसके आदान-प्रदान के लिये पूरी तरह सहमत नहीं होता है तो ग्राहक की गोपनीयता की सुरक्षा की जाती है। अधिक खर्चीला होने के कारण कंपनियां इसका विरोध करती हैं तथा यह अधिकतर क्षेत्रों में कानून नहीं है। वास्तव में किसी व्यक्ति के अधिकारों की सुरक्षा सुनिश्चित करने के लिये यदि 'आप्ट इन' पद्धति के अलावा उसे यह बताया जाए कि कौन-सी सूचना का उपयोग किया जाएगा तो बेहतर होगा, लेकिन कंपनियां साधारणत: ऐसा कदम नहीं उठातीं।

वर्ष 1999 से अमेरिकी संघीय विनियमों द्वारा एचआईपीएए (स्वास्थ्य बीमा वहनीयता एवं उत्तरदायित्व अधिनियम), जो 'आप्ट-इन' का उपयोग करता है तथा जिसके पास चिकित्सकों तथा अन्य मेडिकल प्रैक्टिशनरों के लिये सार्थक ग्राहक सूचना है, के लिये गोपनीयता आवश्यकताएं स्थापित की गईं।

भारत में आम सूचना सुरक्षा नहीं है। फिर भी भारत के शीर्ष बैंक द्वारा ष्टिकोण में परिवर्तन लाया गया। जैसा कि हम जानते हैं, आरबीआई ने 'अपने ग्राहक को जानें' (केवाईसी) प्रक्रिया के अंतर्गत बैंकों से कहा है कि वे अपनी सभी शाखाओं को निर्देश दें कि काले धन को वैध बनाने से रोकने के उद्देश्य से वे अपने ग्राहकों से सूचना एकत्र करें।

हाल ही में उसने ग्राहक सूचना पर निर्देश देते हुये परिपत्र जारी किया। यह परिपत्र कहता है कि ग्राहक से जुटाई गई सूचना का उपयोग जब बैंकों, उनके अधीन के उपक्रमों और संबद्ध कंपनियों द्वारा परस्पर बिक्री के लिये किया जाता है तो ऐसी सूचना अन्य एजेंसियों को भी उपलब्ध करा दी जाती है। यह परिपत्र बैंकों को यह बताना चाहता है कि खाता खुलवाते समय केवाईसी की पूर्णता के लिये ग्राहक द्वारा उपलब्ध कराई गई सूचना गोपनीय होती है तथा परस्पर बिक्री या किसी अन्य उद्देश्य के लिये उसमें से किसी विवरण का उपयोग करना ग्राहक गोपनीयता वचन का उल्लंघन होगा। बैंकों को सलाह दी गई कि वह अपनी सभी शाखाओं को इस संदर्भ में ग्राहक के प्रति वचनबद्धता को सुनिश्चित करने का निर्देश दें।

इसके अतिरिक्त यह निर्दिष्ट किया गया है कि यदि बैंक केवाईसी आवश्यकताओं को छोड़ अन्य किसी उद्देश्य के लिये ग्राहक के बारे में कोई सूचना जुटाना चाहते हैं, तो वह खाता आरंभ फ़ार्म में से नहीं ली जाएगी। ऐसी सूचना ग्राहक को सूचना जुटाने का उद्देश्य बताकर तथा उसका अनुमोदन लेकर पृथक रूप से जुटाई जा सकती है। वित्तीय सूचना गोपनीयता के प्रति आरबीआई का यह ईमानदारीपूर्ण एवं सतर्क कदम है।

ग्राहक सूचना के आदान-प्रदान का मामला पूरे विश्व में उठाया गया तथा अंतर्राष्ट्रीय स्तर पर कई प्रतिनिधित्व अपनाये गये। भारतीय परिश्य में यह अभी प्रश्न ही बना हुआ है कि क्या ग्राहक को इस प्रकार के आदान-प्रदान से इनकार करने का विकल्प दिये बिना ही ग्राहक सूचना का इस प्रकार का आदान-प्रदान करना गोपनीयता के अधिकार का उल्लंघन होगा?

इस परिश्य में कंपनियों सहित बीमा कंपनियों द्वारा अपनाये जाने वाले नये व्यापार माध्यमों पर यदि सूचना गोपनीयता कानून प्रवर्तित किया जाए तो उसके निष्कर्षों का परीक्षण करना तथा आने वाले समय में सामने आने वाली नई चुनौतियों का सामना करने के लिये स्वयं को तैयार करना भी आवश्यक है।

बीमा कंपनियों द्वारा स्वयं सर्वेक्षण करवाकर तथा स्वयं का डेटाबेस तैयार कर ऐसी विचित्र स्थिति से निपटा जा सकता है। दूसरा विकल्प यह है कि लोगों को ऐसी सूचना लेते समय संस्थान/संगठन ग्राहकों के समक्ष अपनी गोपनीयता नीति घोषित करें तथा उन्हें यह बताएं कि ऐसी सूचना अन्य उत्पादों, जैसे बीमा के विपणन के लिये उपयोग में लाई जा सकती है। इससे आरबीआई द्वारा बैंकों के मामले में घोषित किये गये अनुसार ऐसी सूचना के आदान-प्रदान की अनुमति देना या न देना स्पष्ट हो जाएगा।

पूरे विश्व में ई-कॉमर्स में वृद्धि हुई है तथा भारत भी इसमें पीछे नहीं है। ई-कामर्स को एक व्यापार पद्धति के रूप में अपना लिया गया है तथा बीमा कंपनियां भी व्यापार के वैकल्पिक माध्यम के रूप में इस पर विचार कर रही हैं। इलेक्ट्रानिक कॉमर्स के लिये व्यापक विनियम वातावरण उपलब्ध कराने के उद्देश्य से भारत सरकार ने मई, 2000 में अपना पहला साइबर लॉ सूचना तकनीक अधिनियम पारित किया। यह आईटी अधिनियम अन्य बातों के साथ निम्नलिखित को शामित करता है :-

श यह भारत में ई-मेल को कानूनी रूप से संचार का एक वैध रूप स्वीकृत करता है। किसी भी प्रस्ताव की इलेक्ट्रानिक रूप में स्वीकृति को भी कानूनी एवं प्रभावी घोषित किया गया।

श इस नये अधिनियम ने भारतीय कानून में पहली बार डिजीटल हस्ताक्षर की स्वीकृति दी।

श उक्त नये कानून ने संरचना की अधिक्रम सोपानिकी, प्रमाणीकरण अधिकारियों के लिये एक नियंत्रक, न्याय अधिकारी तथा साइबर अपीली न्यायाधिकरण के गठन की भी स्वीकृति दी।

अन्य संविदाओं की तरह बीमा को भारतीय संविदा अधिनियम, 1987 में उल्लिखित आवश्यकताओं को पूरा करना होता है तथा इसके अलावा कुछ अतिरिक्त तत्व भी होते हैं, जैसे बीमा योग्य हित का सिद्धांत (समुद्री बीमा अधिनियम, 1963 में परिभाषित), परम सद्भाव सिद्धांत। यद्पि बीमा अधिनियम, 1938 में इन शर्तों को विशेष रूप से परिभाषित नहीं किया गया है। बीमा संविदा एक उचित प्रस्ताव एवं स्वीकार्यता भी चाहती है।

आईआरडीए (पॉलिसीधारकों के हितों की सुरक्षा) विनियम, 2002 समुद्री पॉलिसियों के मामले को छोड़ लिखित प्रस्तावों के लिये एक आदेश है। यह प्रस्ताव बीमा की संविदा का आधार बनाता है तथा यह काफ़ी अधिक महत्वपूर्ण है, क्योंकि इसमें प्रस्तावक से घोषणा ली जाती है कि उसके द्वारा दिया गया वक्तव्य और सूचना सत्य है।

यहां यह उल्लेख करना भी जरूरी है कि इलेक्ट्रानिक रिकार्डों की स्वीकार्यता प्रवेश्यता के संदर्भ में प्रावधानों को शामिल करने के लिये भारतीय साक्ष्य अधिनियम में संशोधन किया गया।

बीमाकृत व्यक्ति, जो ऐसी पॉलिसियों को इलेक्ट्रानिक रूप से प्राप्त करने पर सहमत हो जाता है, को पॉलिसियों के ऐसे इलेक्ट्रानिक निर्गमन को तब तक शामिल नहीं किया जा सकता, जब तक कि सहमत बीमाकृत व्यक्ति को प्रदान की गई बीमा पॉलिसियां बीमा अधिनियम, 1938 तथा आईआरडीए द्वारा बनाये गये विनियमों में उल्लिखित आवश्यकताओं को पूरा नहीं करतीं तथा उसमें कानून का उल्लंघन न हो। इसके अतिरिक्त पॉलिसी फ़ार्म फ़ार्मेट एवं भाषा, जो बीमा कंपनी द्वारा 'फ़ाइल एंड यूज़' प्रक्रिया के अंतर्गत नियामक के साथ उपयोग में लाई गई है, को शामिल किया जाना चाहिये। इसमें यह प्रश्न नहीं है कि पॉलिसी किसी रूप (पेपर या इलेक्ट्रानिक) में है। पॉलिसियों के इस प्रकार के इलेक्ट्रानिक निर्गमन का उदाहरण न्यूयार्क है, जहां पॉलिसियों के ऐसे इलेक्ट्रानिक निर्गमन की अनुमति है, क्योंकि यह वहां बीमा कानून एवं विनियमों के अंतर्गत प्रतिबंधित नहीं है।

भारत में अपने व्यापार अभियान में इलेक्ट्रानिक डेलिवरी पद्धति का निर्गमन करने की इच्छुक प्रत्येक बीमा कंपनी को स्वयं यह तय कर लेना चाहिये कि इसके लिये कौन-सी तकनीकी अपनाना और कार्यान्वित करना अच्छा होगा तथा उसे स्वयं इस बात की पुष्टि कर लेनी चाहिये कि अपनाई गई ऐसी तकनीकी बीमा अधिनियम एवं विनियमों के प्रावधानों के पालन के लिये पूरी तरह अनुकूल है। ऐसी कंपनी को यह सुनिश्चित कर लेना चाहिये कि ऐसी दी गई पॉलिसी में किसी अन्य व्यक्ति द्वारा फेर-बदल नहीं किया जा सकता।

बीमा उद्योग द्वारा ई-तकनीकी का इस प्रकार का सकारात्मक उपयोग उसे काफ़ी बल प्रदान करेगा तथा विपणन में आसान, तीव्र और सुविधाजनक सहायता प्रदान करेगा।

लेखक आईआरडीए के सहायक निदेशक हैं। यहां व्यक्त विचार उनके निजी हैं।

विकल्प

'बनाएं एक प्रभावशाली व्यवस्था'

-मनुभाई शाह

(लेखक ने उपभोक्ता शिकायतों से संबंधित तंत्र पर व्यापक नज़रिया अपनाया है। इस पर आईआरडीए, बीमा संस्थान एवं सरकार को ध्यान देने की आवश्यकता है।)

पिछले दो दशकों से अधिक समय तक उपभोक्ता शिक्षा एवं अनुसंधान केंद्र (सीईआरसी) में हमारे पास जीवन एवं गैर-जीवन दोनों से संबंधित तमाम प्रकार की बीमा शिकायतें निपटाने व सुनने का मौक़ा मिला।

वास्तव में इस लेख में मैं यह बताना चाहता हूँ कि आईआरडीए या अन्य बीमा परिषदों की शिकायतों को सुलझाने में क्या भूमिका है, वो किस तरह से काम करें। व्यापक समस्याओं के संदर्भ में उनको किस तरह से निपटाएं। कुछ ऐसे मुद्दे हैं, जिन पर व्यापक नज़रिये की आवश्यकता है। दावों को लेकर उपभोक्ताओं की शिकायतों के अतिरिक्त भी बड़ी-बड़ी समस्याएँ हैं, लेकिन वह एक अलग मुद्दा है। इस लेख में इन्हीं बिंदुओं को स्पष्ट किया जाएगा।

पॉलिसी धारकों की शिकायतों से संबद्ध कानून भारतीय कानून आयोग ने जीआरए यानी पृथक शिकायत निवारण प्राधिकरण गठित करने की सिफ़ारिश की थी। प्राधिकरण को कुछ अधिकार भी देने की बात की गई है। भारतीय कानून आयोग की सिफ़ारिशें एवं अपना ष्टिकोण मैं इस लेख में दे रहा हूँ :-

उपर्युक्त विषयों पर आयोग ने अपनी रिपोर्ट में ढेर सारी सिफ़ारिशें की हैं। आयोग ने जीआरए के संबंध में सुझाव दिया है कि बड़े शहरों एवं देश के चार महानगरों में अपीलीय अधिकरण का गठन किया जाए। इसी तरह से सभी बड़े शहरों में जीआरए के गठन की बात की है। आयोग ने बीमा एजेंट सर्वेक्षक के बीच संभावित विवादों के निपटारे के लिये अधिकार जीआरए को देने की बात की है। पॉलिसी धारकों की शिकायतों के अतिरिक्त इससे उनको पहुँचने वाली क्षति को भी जीआरए के अधिकार क्षेत्र में लाने की बात की है।

विधि आयोग के सदस्यों के प्रति पूरा सम्मान व्यक्त करते हुये मैं यह स्पष्ट करता हूँ कि आयोग की उक्त सिफ़ारिशों से मैं सहमत नहीं हूँ। उपभोक्ताओं के आधारभूत चार अधिकारों में से एक तीव्र एवं क़ीमती शिकायतों के समाधान की व्यवस्था है। भारत जैसे विशाल देश के लिये शिकायत निवारण प्रकोष्ठ की हर बड़े शहरों में जरूरत पड़ेगी। यह न केवल महंगा और अपर्याप्त है, बल्कि दिक्कत भरा भी है।

शिकायत निवारण प्राधिकरण प्रभावशाली तभी होगा, जब उसकी पहुंच उपभोक्ताओं तक हो। इस संदर्भ में उपभोक्ता संरक्षण अधिनियम जिला, राज्य एवं राष्ट्रीय स्तर पर मंच और आयोग बनाना अपेक्षाकृत बेहतर होगा। इससे प्रत्येक नागरिक या किसी को भी अपना सुख-दुख फ़ोरम या आयोग में ले जाने में सुविधा होगी। यदि उपभोक्ता को अपनी शिकायतें लेकर राज्य की राजधानी में इधर-उधर दौड़ना पड़ेगा तो उससे बेहतर यह आयोग या मंच ही हैं। आयोग में जाना सरल भी होगा। उपभोक्ता संरक्षण अधिनियम के तहत गठित जिला फोरम, राज्य फोरम एवं राष्ट्रीय आयोग अच्छा ही कर रहे हैं यहां मेरा ऐसा कुछ कहना नहीं है। उनमें कुछ नया जोड़ने की आवश्यकता है। उसमें नये विकल्प और सुधार की आवश्यकता है। लेकिन यह भारत के विधि आयोग द्वारा सुझाये गये शिकायत निवारण प्राधिकरण की अपेक्षा बेहतर हैं। कागजों पर बहस चलाने से बेहतर जिला फोरम एवं राज्यों के आयोगों में कुछ बदलाव करना ज्यादा प्रभावशाली होगा, लेकिन विधि आयोग का उपर्युक्त सुझाव पॉलिसी धारकों के लिये ज्यादा नुकसान दायक है। इससे तो उपभोक्ता का मूलभूत अधिकार तीव्र एवं जल्द व सस्ता शिकायत निवारण का अधिकार ही खत्म हो जाता है।

पिछले 14 वर्षों में जिला फोरमों, राज्य आयोगों एवं राष्ट्रीय आयोग को और अधिक प्रभावशाली बनाने के लिये समय-समय पर तमाम संशोधन किये गये और नये प्रस्ताव जोड़े गये। नि:संदेह इन आयोगों में अभी भी सुधार की आवश्यकता है। संसद द्वारा हाल ही में किया गया संशोधन एवं 15 मार्च 2003 से लागू हुआ प्रस्ताव जिला फोरमों एवं आयोगों के सुधार के लिये विचारणीय है। इससे उनकी कार्यप्रणाली में उल्लेखनीय सुधार हुआ है।

बहरहाल, जिला फोरमों एवं राज्य आयोगों को प्रभावशाली बनाने के लिये पहले से ही कुछ सुझाव दिये गये हैं। ये सुझाव उपभोक्ता कल्याण मंत्रालय के समक्ष विचाराधीन हैं। आज देश में करीब 500 जिला फोरम हैं और बीस लाख रुपये तक के दावों की सुनवाई का आर्थिक संबंधी विचारण इनके क्षेत्राधिकार में शामिल है। 20 लाख रुपये से अधिक के दावे की सुनवाई करने का अधिकार राज्य आयोगों का है। राज्य आयोग एक करोड़ रुपये तक के दावे की सुनवाई कर सकते हैं।

राष्ट्रीय उपभोक्ता विवाद निवारण आयोग, दिल्ली सर्वोच्च संस्थान है। यह वास्तविक रूप से वित्तीय अधिकार संपन्न है। एक करोड़ रुपये से ऊपर असीमित वित्तीय दावों की सुनवाई करने का अधिकार इस आयोग के पास सुरक्षित है। राज्य आयोगों के निर्णयों पर अपीलीय अधिकार भी राष्ट्रीय आयोग के पास है। राष्ट्रीय आयोग के विरुद्ध अपील केवल सर्वोच्च न्यायालय में ही की जा सकती है।

अमेरिका एवं विकसित देशों में इस संदर्भ में बहुत अच्छा एवं स्वस्थ तरीका अपनाया जाता है। वहां बीमा कंपनियों की स्वतंत्र 'रेटिंग' की जाती है। 'रेटिंग' अध्यन स्वतंत्र रूप से व्यावसायिक संस्थान एवं इकाइयां करती हैं। यह रेटिंग जीवन बीमा एवं संपत्ति बीमा दोनों की स्वतंत्र रूप से की जाती है। बीमा कंपनियों की रेटिंग उनकी सेवाओं की गुणवत्ता, पॉलिसी धारकों के साथ उनका व्यवहार, दावों का निपटारा, दावों को निपटाने में लगने वाला समय, निपटारे में स्वच्छता, निष्पक्षता एवं अनिष्पक्षता, शर्तों की दशाएं एवं अवधि आदि के आधार पर तय की जाती है।

यह रेटिंग सर्वोच्च उपयुक्त फर्म, स्टैंडर्ड एवं असंतोषजनक और अन्य वर्ग श्रेणियों में की जाती है और रेटिंग एवं कंपनियों को बाक़ायदा प्रकाशित किया जाता है। अब समय आ गया है कि भारत में भी इसी तरह का प्रयास किया जाए। बीमा कंपनियों को व्यावसायिक कुशल मूल्यांकन प्रणाली सामूहिक रूप से शुरू करनी चाहिये और अर्ध'न कर तैयार की गई रेटिंग व कंपनियों के कार्य प्रदर्शन को बाक़ायदा प्रकाशित किया जाना चाहिए। आम आदमी के हित में इसे प्रचारित भी किया जाना चाहिए।

प्रतिस्पर्धा के इस युग में तमाम सुधारात्मक बदलाव किये जा रहे हैं। पहले इस तरह की धारणा का अभाव था। उपभोक्ताओं की सुविधा पर कोई विशेष ध्यान नहीं दिया जाता था। आज-कल यदि उपभोक्ताओं का ध्यान नहीं रखा गया और निदानात्मक कदम नहीं उठाए गए तो इस युग में किसी भी कंपनी का टिक पाना संभव नहीं होगा।

जब केवल सरकारी कंपनियां ही बीमा क्षेत्र में थीं, तब वहां भ्रष्टाचार की कोई बात नहीं थी। यह स्वाभाविक है। विराष्ट्रीयकरण के बाद जीवन बीमा क्षेत्र में संपत्ति एवं गैर-संपत्ति बीमा करने वाली तमाम निजी क्षेत्र की कंपनियां कुकुरमुत्ते की तरह उग आयी हैं। ईश्वर ही जाने कि किस बीमा कंपनी में कब भ्रष्टाचार हो जाए।

तब यह सवाल उठता है कि पॉलिसी धारकों के हितों की रक्षा कैसे की जाए, जिनके बीमा राशि की परिपक्वता के

बाद पुनर्वापसी या दावे बनते हैं। मैं समझता हूं कि भारत में बीमाधारकों के हितों की रक्षा के लिये यूके मॉडल के सुझाए गये बिंदुओं से कहीं बेहतर हम अन्य तरीका अपना सकते हैं।

ब्रिटेन ने एक कानून पास किया। इसे पॉलिसी धारक संरक्षण अधिनियम 1975 से जाना जाता है। इस अधिनियम में 1997 में संशोधन किया गया। इस अधिनियम में संबद्ध शेयर धारकों की रक्षा के लिये सम्मिलित सभी शेयर धारकों का प्रतिनिधित्व करने वाले बोर्ड ऑफ़ डायरेक्टर्स के गठन की बात कही गई है। इसका उद्देश्य किसी भी बीमा कंपनी के भ्रष्ट होने पर पॉलिसी धारकों के हितों की रक्षा के लिये एक कोष बनाना है। इसमें सामान्य एवं जीवन बीमा कंपनियों के लिये अलग-अलग प्रावधान किया गया है।

यदि सामान्य बीमा कंपनी भ्रष्ट हो जाती है तो इसका मूल्यांकन पूरी तरह से कंपनी की जिम्मेदारी पर किया जाएगा और तब सामान्य बीमा उद्योग में उसकी प्रीमियम आय को संबद्ध कोष में समुचित ढंग से वितरित किया जाएगा। इस कोष का उपयोग भ्रष्ट सामान्य बीमा कंपनी की जिम्मेदारी पर मूल्यांकित किया जाएगा।

जीवन बीमा कंपनियों के मामले में उनकी सामान्य योजनाएं एवं दीर्घावधि और पॉलिसीधारकों की तात्कालिक देयता उतनी अधिक नहीं है, जितनी सामान्य बीमा कंपनियों के भ्रष्ट होने पर होती है। इसी कारण इनके लिये प्रावधान बनाए गए हैं।

तात्कालिक पूर्ण देयता के लिये बीमा कंपनियां अपने प्रीमियम आय का एक हिस्सा कोष में योगदान देंगी, लेकिन दीर्घावधि पॉलिसियों की निरंतरता के संबंध में जीवन बीमा कंपनी अपनी सुविधानुसार भविष्य के प्रीमियम इकट्ठा करेगी और बीमा पूर्ण हो जाने या मृत्यु की दशा में जीवन बीमा धारक को अदायगी करेगी। यह उस मामले में भी समान रूप से लागू होगा। उनके (बीमा कंपनी) दिवालिया होने की तारीख से सैद्धांतिक प्रोद्भूत देयता मूल्यांकन के बाद बीमा किश्त से प्राप्त आय के आधार पर तय किया जाएगा।

मेरी सूचना और जानकारी के हिसाब से उपर्युक्त मॉडल सबसे उपयुक्त है। राष्ट्रीयकरण के दौरान हम भारतीयों को दिवालिये का कोई खतरा नहीं था और भारतीय कंपनियां सरकार के अधीन थीं। अब विराष्ट्रीयकरण होने एवं बीमा क्षेत्र को निजी कंपनियों के लिये खोल देने और पब्लिक लिमिटेड कंपनियों के प्रोत्साहन, सहकारी कंपनियों के बीमा क्षेत्र में आने से जल्द ही हमें उसी तरह के समान कानून का प्रारूप तैयार करना बेहतर होगा।

हमारी बीमा कंपनियां अधिकांशत: या तो पूरे दावे को स्वीकार करती हैं या नकार देती हैं, लेकिन वो बीमाधारक के प्रति मानवीय मैत्री भाव से नहीं सोचती हैं और वे तात्कालिक रूप से पॉलिसी धारक को कोई भुगतान करने की आवश्यकता नहीं समझतीं। उनके दावे का सही समय पर निपटारा नहीं करतीं। ऑन अकाउंट अदायगी भी सामान्य बीमाधारकों के साथ लागू नहीं की जाती, जबकि उद्योगों की बीमा अदायगी ऑन अकाउंट कर दी जाती है। ऑन अकाउंट अदायगी तात्कालिक एवं कम समय में हो जाती है।

उदाहरण के लिये यदि पॉलिसी धारक का घर भूकंप, आग या अन्य कारणों से गिर जाता है तो दावे के भुगतान के लिये बीमा कंपनी को पूरे मामले को विस्तार से देखने के लिये समय की आवश्यकता पड़ेगी, लेकिन औद्योगिक रूप से विकसित देशों में बीमा कंपनियां सबसे पहले पॉलिसी धारक को निश्चित राशि प्रदान कर सहायता प्रदान करती है। अब समय आ गया है कि भारत में जीवन बीमा कंपनियां अंतरिम मामलों में दावे के पूर्णत: निपटान के पहले राहत पहुंचाने और ऑन अकाउंट भुगतान करने पर विचार करें।

यहां तक कि मोटर दुर्घटना में सामान्य बीमा कंपनियों के यदि निपटान दावे के पहले सुलझा सकें तो अनावश्यक खर्च से बचा जा सकेगा। बीमा कंपनियों को इस पर ध्यान देना चाहिये। इस संबंध में मैक्ट द्वारा प्रदान की गई अनुग्रह राशि को ध्यान में रखना चाहिये।

मुझे याद है कि जब मैं जीआईसी बोर्ड में था, तब न्यू इंडिया के चेयरमैन ने एक नई पहल की थी। उन्होंने गुजरात में पुलिस महानिदेशक के साथ एक सम्मेलन किया था, जिसमें वाहन दुर्घटना की तात्कालिक सूचना घटनास्थल से ही प्राप्त किये जाने पर विचार किया गया था। इसमें अनुग्रह राशि दावे के निपटान को भी शामिल किया गया था, ताकि दुर्घटनाग्रस्त व्यक्ति के परिवार या आश्रित तत्कालिक रूप से आर्थिक सहायता प्राप्त कर सकें। इससे बीमा कंपनी बाद में मूल्यांकन करने के अतिरिक्त खर्च से बच सकेगी।

इसी तरह की पहल उपभोक्ता शिकायत के निपटारे एवं मानवीय मुद्दों को समझने में भी की जा सकती है। इससे बीमा कंपनियों एवं उनके ग्राहकों की सहायता होगी। हम अभी तक वाहन दुर्घटनाओं के मामले में पर्यवेक्षक या बीमा अभिकर्ता, बीमा कंपनी के अधिकारियों, गैरेज मेकैनिकों, पुलिस वालों एवं कुछ मामलों में स्वयं पॉलिसी धारकों के भ्रष्टाचार पर ध्यान नहीं देते हैं। यह स्थिति आज भी बनी हुई है। हम समय की बात करते हैं या फिर कहते हैं कि वाहन बीमा एक घाटे का सौदा है और जबकि वहां सभी प्रकार के संगत एवं असंगत काम बीमा कंपनियों द्वारा इसलिये अपनाये जाते हैं कि वे अनिवार्य तीसरी पार्टी से देयता स्वीकृति से बचें, जबकि कानूनों के मुताबिक उपभोक्ता सड़क पर खुद वाहन नहीं चला रहा था, अन्यथा उसे क्षतिपूर्ति प्रदान की जाती।

यह प्रश्न अभी भी बना हुआ है कि मोटर वाहन बीमा व्यवसाय घाटे का सौदा क्यों है और इस संबंध में किस तरह के कदम उठाये जाने की आवश्यकता है। यह प्रश्न पूरे मामले का केंद्र है। विवेक देबराय की अध्यक्षता में कार्यरत समूह के एक रिपोर्ट की चर्चा रोचक होगा। रिपोर्ट में मोटर वाहन दुर्घटना दावे दिल्ली के मामले पर अध्‍ययन किया गया था। इसमें दुर्घटनाग्रस्त वाहन के मरम्मत खर्च की बात शामिल है। रिपोर्ट में विस्तार से विश्लेषण किया गया है, जिसमें दुपहिया वाहन, तिपहिया, चौपहिया, बसों, ट्रकों के बीमा में व्याप्त भ्रष्ट गतिविधियों को विस्तार से बताया गया है। रिपोर्ट में अलग-अलग वाहनों के मामले में अलग-अलग तरह से व्याप्त भ्रष्टाचार के मामले पर चर्चा की गई है।

भ्रष्टाचार को समाप्त करने के लिये आखिर बीमा कंपनियों द्वारा क्या कदम उठाये जा रहे हैं? यदि इस प्रश्न पर विचार किया जाए तो तमाम उपभोक्ताओं की शिकायतों में क्षतिपूर्ति न देने एवं दावे के निपटारे में अनवरत देरी की बात शामिल है।

बिना किसी अतिशयोक्ति के जब मैंने सामान्य बीमा निगम के बोर्ड ऑफ़ गवर्नर के सदस्य के रूप में उपर्युक्त मामले पर एक रिपोर्ट पेश की तो इस रिपोर्ट में यह आग्रह किया गया कि इन मामलों की सीधी जांच सामान्य कंपनियों में कराई जानी चाहिये, जिसमें यह देखा जाना चाहिये कि कंपनियों ने क्या कदम उठाये हैं। भ्रष्टाचार समाप्त करने के लिये क्या किया जा सकता है। सामान्य जीवन बीमा कंपनी ने एक परामर्शदाता नियुक्त किया था, तब से आज दस वर्ष बाद तक हम यह नहीं जानते कि आखिर आगे क्या किया गया।

(लेखक बीमा क्षेत्र में कई वर्षों से कार्यरत हैं। लेखक उपभोक्ता शिक्षा एवं अनुसंधान केंद्र, अहमदाबाद के चेयरमैन (एमराइट्स) हैं।)

IT in Insurance — The Indian Experience

M. Arunachalam

Public Sector – Life Insurance

LIC of India has made policy servicing systems operational all over its branches. Its key technological initiatives have brought in sea changes in the recent years. These include:

- The introduction of front-office computerisation, progressively for various modules of business functions made the transaction processing faster and easier. For example, cash transactions are quicker instead of long waits in queues and inter-branch transactions limited to premiums are accepted. Revival and quotations are generated faster. Errors have been controlled considerably. All the front office modules (Cash, Revival, Claims, SSS, New Business, Policy Issue, Commission processing) have noticeably helped, improving customer service.
- Metro networking and wide area networking has made transaction flow countrywide; a policyholder can make payment for his policy in any office in the country. This is particularly useful in circumstances where a policyholder has multiple policies in different branches, which is usually the case in a city or a major town with more than one branch.
- Internet premium collection particularly for NRIs.

The following areas would require technology advances

- Reduction in paper documents as many registers are still printed
- Streamlining commission for policies serviced in offices other than the home division of the agent
- Automated action on policy options such as removal of accident benefits
- Client-centric premium renewal or other notices – single document for all policies together held by a customer
- Control over policy docket transfers (imaging could be a solution to get over docket misplacement)
- Standardisation of policy format through electronic publishing

LIC is seriously pursuing its efforts to provide a single, personalised point of interaction to the customers, agents, and employees.

- Additional payment methods such as bank debits and credit card

LIC is seriously pursuing its efforts on portal to provide a single, personalised point of interaction to the customers, agents, and employees. It benefits will include payment gateway, requests to service applications, easier upload of data, management tool for the field, and business information dashboard. LIC is also implementing a massive data warehouse to support corporate initiatives in performance management and the like.

Public Sector – General Insurance

"Computerisation in the Indian general insurance industry has not made much progress. The implementation... has been slow... attributed in varying degrees to... technical manpower shortage, inadequacy of hardware, frequent changes made in the software, and lack of maintenance support from hardware vendors."

All the above handicaps no longer apply. Until some years back, transaction processing and management information compilation were partly manual and partly mechanised. In the recent years, processes like proposal capture, policy printing, generation of renewal notices, receipts and vouchers, and consolidation of accounts have been computerised. Policy transactions (front end operation and back office functions) have been shifted to computerised systems.

New India Assurance implemented a package application four years back. It has relieved manual operation to a good extent and brought in transaction efficiency in all operating offices. The same package runs in two of the other public sector companies (viz. United India and National) where the business processes and product characteristics are almost the same. Oriental Insurance has decided upon a different software choice, which is expected to be fully operational by 2005. At present its in-house application software meets requirements.

It is understood that all these companies are planning to network their local databases. Some companies are contemplating workflow management for selective business transactions. While

Oriental Insurance proposes to have a central database connected to all its operating offices, the other three companies have branch level databases, which will be networked for data transfer. Both these models have their merits and demerits. In the former, network traffic among others will require special consideration and in the latter, data is unconsolidated, and analysis and reporting cannot be performed without creating a centralised repository. Will they overcome these drawbacks effectively, and if so how soon?

It is gathered that these areas in the existing package application need attention.

- It is not client based, but contract based; will not allow view of all policies of a client
- Reports are pre-defined; in the changing market and dynamic situation, executives at all levels need reports, statistics and plenty of information. Options are available to generate ad hoc reports but have not been provided.
- For changes to products and customisation of new products, a lifecycle process and vendor support are still needed, as against the present trend that any packaged software allows easy customisation by the client-company
- All systems work in standalone offices, as of now. Without a complete network, crunching of data for the company as a whole is not possible. Data warehouse is a must in an emerging situation and this will require a consolidation of data in a common repository for the organisation as a whole for an effective, complete management information, actuarial analysis, easy generation of statutory reports, and so on.

It is gathered that the package application will have an enterprise version and that will take care of ad hoc reports and consolidation of information through network.

Currently the rates are set and controlled by the Tariff Advisory Committee (TAC) for many lines of business in general insurance. When the industry is heading towards detariffing, and when a large number of products are introduced, the system will require a powerful rating engine.

> The first priority for Indian insurers is a well-designed and integrated core operational system particularly for policy and claims administration.

In addition, the system should provide client-centric features, management information, and decision support, built-in controls including fraud-detection environment, and compliance with regulatory norms, and at an appropriate stage document management solution etc.

The system has to address areas like prompt accounting of reinsurance claims, statistical analysis of risks, rates, and experience. The requirements will change as the broker distribution grows in a big way. Similarly, there will be greater need for interfacing with the external world such as business partners, surveyors and adjusters, reinsurers, crime bureaus, government agencies, and the regulatory authority.

Public sector - reinsurance

GIC moving away from its age-old applications has embarked on major technology initiatives that will enable it to redefine the way it does business with cedants and brokers. The initiatives aim at keeping business transactions homogeneous and simple, and looking at process efficiencies.

GIC as in the case of many reinsurers is keen on: accumulation and exposure control, Decision Support Systems ('What if' analysis), co-ordination of Treaty and Facultative business to manage accumulations and accessing knowledge on reinsurance risks on global basis. Reinsurers around the world have achieved considerable business benefits by aligning business objectives with IT, which has helped them to compete effectively. The benefits of IT based business processes would also help in improved quotation process, negotiation, binding of risk, consistent underwriting, and reliable data to support decision-making and achieve straight-through processing including web-enablement.

The only answer is an integrated, high-end processing system. Currently, GIC of India is seriously pursuing its efforts in implementing enterprise-wide solutions using SAP.

Private sector

More than twenty companies are in operation. Either they have found systems as with their foreign

alliance partners across Mainframes, AS/400, and Client/ Server (such as LIFE/Asia 400, Asia, SOLCORP Ingenium, S3) or have embarked on their own development incrementally. Most of them have centralised databases. Some of them have web enabled facilities like on-line premium calculation and other sophisticated features.

None of the systems as existing abroad can easily fit into Indian business conditions and most of these systems if not built custom-specific require massive customisation. Environment, architecture and functionality are different with each insurer, and these are yet to be fully stabilised. In-depth analysis is more relevant in respect of private insurers who are all in the initial years until they break-even.

It is gathered that the private insurers have evolved different models for analysis such as strategic operational business planning, business and performance reviews, capital projections and management, product pricing and expenses analysis and so on which increasingly need IT. However, a well-built management information system, which will have data from all operation and analysis, still remains to be established. For instance, to perform lapse analysis, queries have to be written and data extracted and put in spreadsheet for analysis. Ideally MIS to a great extent should be the byproduct of the core operational system. Excel is used widely as a tool for MIS generation though various analytical tools are available in the market for actuarial, financial and marketing analysis.

Planning IT Strategy

"As insurance is an information intensive business, ... insurance companies should improve their technical proficiency by upgrading their information support and by developing strong R&D departments...the growth in trade, commerce, industry, and other segments of the economy is throwing up an increasing volume of data. The insurance industry can usefully handle the large mass of data needed by it only if its information management is supported by information technology. This would require a measure of futuristic planning with the help of in-house as well as outside professionals, going well beyond the present limited applications of computers. Managements... should accept meaningful computerisation as a total managerial responsibility and adopt appropriate strategies for its implementation

> Successful organisations around the world ensure that their IT strategy and implementation roadmap are aligned to their overall business vision.

Computerisation is capital intensive where obsolescence of technology is rapid. The need for careful long-term planning...with due consideration to costs and benefits cannot be overstated."

The key management priorities will be

- Demonstrating business values of information technology and services
- Developing leadership in the senior IT team
- Strengthening IT and business linkage, and
- Making IT more service oriented.

Technology management has to quickly learn what is important by drawing on the best technical people for advice and applying judgment in an overall business context with right technological options. The decision to 'Build or Buy' requires serious consideration, which is a challenge.

The CIO (carrying different titles) has emerged as an important member of the company's top management. Such is his importance that he is today required to sign the annual statements in the US. The CIO in advanced countries provides needed information and insight to organisational heads so as to achieve the best use of technology. He brings out his technology mission, strategy and tactical measures, to align with evolving business goals, and constantly elicits opinion from all stakeholders. The CIO coordinates all technological aspects on ongoing basis, advises on technological issues that the board or CEO raise and acts as an arbitrator in resolving any internal technological management issues. The CIO as a technological visionary:

- Ensures that the corporate and business unit strategies incorporate critical technological perspectives
- Gathers knowledge on current and emerging technologies that will impact the competitive position of the company

The Way Forward

Insurers have to focus on the following imperatives and consider various technological options depending on the business and IT strategies.

- *Core System*: The first priority for Indian insurers is a well-designed and integrated core operational system particularly for policy and claim administration, with these characteristics: user-friendly, efficient, consistently dependable, flexible to add on new products, easy to configure new features, networked for data flow, interfaced to an MIS repository and external agencies, and built in with complete controls. Today, every insurer is looking at augmenting or replacing the system for tight integration, component-based architecture, high levels of automation and security over data, Internet enabling and 'straight-through-processing' plus the ability to deliver rule-based intelligence all the way back to the point of sale. Though it is not easy to establish all the desired criteria, they need to be achieved to gain a competitive edge.
- *Client Interface*: Equally important is building of good customer facing applications. One important requisite will be to have more thrust on client's view rather than contract view. CRM tool is one option for achieving unified view of a customer. The interfaces will include agents, brokers, reinsurers, banks, and adjusters all of which enhances operational experience of the customers. On the distribution side, new channels will open up, distributors will become Internet savvy and will be empowered to conduct more real time transactions with access to related products and services.
- *MIS*: The core operational system should automatically provide the data needed for reporting, analysis and intelligence. It should help companies spot the exceptional trends, such as high expense ratio, heavy lapses, adverse loss experience and instances of fraudulent claims.

The importance of integrating people with technology needs no emphasis. Even the best systems will fail if they are not synchronised with company structure and staff expectations from technology.

- *Industry Collaboration*: An important requirement will be a common database that will serve as information pool to which individual insurers will supply data and request information. Examples of such information providers in US are: Choice Point (for claims information), Insurance Services Office (for a variety of services like common policy formats), Department of Motor Vehicles (for motor vehicle reports), Medical Information Bureau (for health information), Intellisys (for tele-interviews) and so on. The US has developed a common database that contains information on approximately 3.3 million insurance agents.

In India, TAC is reported to be building a database for declined lives. An industry-wide, concerted effort is needed to stamp out insurance fraud. When multiple insurers now operate in India, information has to flow in and out to such industry-wide databases. Further, the criticality of statistics like mortality, morbidity, and experience, and lapse analysis for the entire insurance industry needs no special mention. IT systems should have strong foundation to provide for such eventual requirements.

Finally, the importance of integrating people with technology needs no emphasis. Even the best systems will fail if they are not synchronised with company structure and staff expectations from technology.

Successful organisations around the world ensure that their IT strategy and their implementation roadmap are aligned to their overall business vision. IT strategies can succeed only with the top management commitment, key stakeholders' participation and CIO's vision.

Concluded

The author is Advisor, Insurance, HCL Technologies Ltd. The views expressed here are his own.

Report Card: GENERAL

Growth drops to 12 % in July

G. V. Rao

Performance in July 2004

The growth rate and the quantum of accretion in the month of July 2004 have both dropped from what was achieved in June 2004. While it was an accretion of Rs. 194 crore (16.5 per cent growth) in June 2004, it is only Rs. 156 crore (11.7 per cent growth) in July 2004. The new players had recorded Rs. 88 crore (58 per cent growth) in June have yet again recorded a healthy increase of Rs. 97 crore (58 per cent), contributing their significant part to the industry's performance in July.

A growth rate of 11.7 per cent for July 2004 is lower when compared to the recorded growth rate of 13.75 per cent, as at the end of June 2004.

Established companies

What has been the reason for the overall lowered performance of the market? The established players have recorded only Rs. 58 crore (five per cent growth—without ECGC it is 4.4 per cent) in July compared to their performance in June of Rs. 93 crore (9.4 per cent). United India in July has lost a premium of Rs. 41 crore (-13.7 per cent) and this has pulled down this sector's overall performance. This shortfall has been made up by Oriental's growth rate of 10 per cent and that of National Insurance of 14.7 per cent, a relatively subdued performance by the latter compared to its spectacular earlier growth rates.

With National Insurance showing a lower growth rate and the United India actually decelerating has thrown up new concerns about the performance of the group as a whole.

New companies

Among the new non-life insurance companies, a pattern seems to be emerging with ICICI Lombard, with an accretion of Rs. 36 crore (116 per cent) in July continuing its pronounced aggressive march, widening its lead

GROSS DIRECT PREMIUM (within India) JULY, 2004

(Rs.in lakhs)

INSURER	PREMIUM 2004-05		PREMIUM 2003-04		MARKET SHARE UPTO JULY, 2004	GROWTH % YEAR ON YEAR
	FOR JULY 04	UPTO JULY 04	FOR JULY 03	UPTO JULY 03		
Royal Sundaram*	2,603.35	10,724.00	1,800.14	8,849.00	1.68	21.19
Tata AIG*	4,098.99	17,720.06	2,401.07	13,821.69	2.78	28.20
Reliance General	994.18	6,229.73	1,605.50	6,834.01	0.98	-8.84
IFFCO-Tokio	3,534.24	17,243.98	2,417.16	12,891.28	2.71	33.76
ICICI lombard	6,682.74	28,731.12	3,142.48	15,757.90	4.51	82.33
Bajaj Allianz	5,567.94	26,599.16	4,183.56	16,088.31	4.17	65.33
HDFC	1,535.03	5,319.38	746.26	1,938.95	0.83	174.34
Cholamandalam	1,527.57	6,154.74	615.66	3,031.41	0.97	103.03
New India*	31,441.00	1,40,488.00	29,867.00	1,35,575.00	22.05	3.62
National*	32,985.00	1,39,112.00	27,875.00	1,11,216.00	21.83	25.08
United India*	25,731.00	1,11,533.00	29,834.00	1,15,244.00	17.50	-3.22
Oriental*	27,427.34	1,11,334.97	24,929.41	1,05,790.62	17.47	5.24
ECGC	4,537.68	16,059.82	3,745.79	13,195.12	2.52	21.71
TOTAL	**1,48,666.06**	**6,37,249.96**	**1,33,163.03**	**5,60,233.29**	**100.00**	**13.75**

**** Data revised by the respective insurers for the corresponding month of the previous year.***

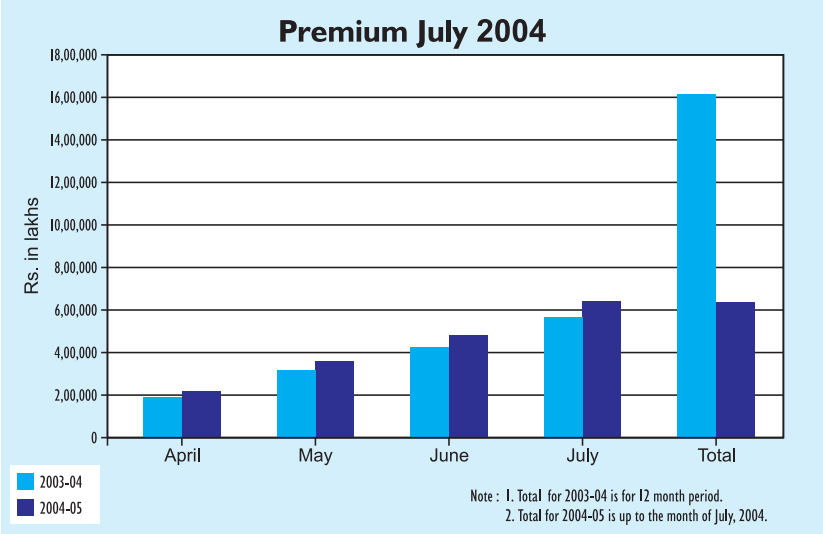
further by another Rs. 12 crore over its nearest competitor Bajaj Allianz, which recorded an accretion of Rs. 24 crores. Tata AIG and Iffco-Tokio seem to be in one league with accretions of Rs. 17 and Rs. 11 crore respectively. The new players seem to be on a consistent course of not only showing high growth rates each month – which can be attributed to the relatively low base - but adding to the performance accretions of the market in quantum as well.

The ECGC has maintained its growth rate of 20 per cent.

Performance up to July 200

The quantum accretion of the industry at the end of July 2004 is Rs. 770 crore (13.75 per cent growth). The new companies' contribution to this quantum is Rs. 394 crore (50 per cent growth) and that of the established companies Rs. 376 crore (7.8 per cent growth). The growth rate at the end of June was 14 per cent and it has dropped slightly at the end of July to 13.75 per cent.

Among the new players, ICICI Lombard has completed a business of Rs. 287 crore up to July recording a quantum accretion of Rs. 130 crores, ranking next only to National Insurance that has recorded an accretion of Rs. 280 crores, followed by Bajaj Allianz with Rs. 104 crores. United India that had an accretion of Rs. six crore at the end June has dropped its premium by Rs. 37 crore at the end of July 2004; the only other insurer that has dropped in premium quantum premium is Reliance General.



Conclusion

What would ultimately lift the growth rate of the industry will largely depend upon how well the established players perform in the future. With National Insurance's growth rate decelerating in July from the earlier unprecedented levels and with UIIC dropping premium income rather significantly in July, the signals emanating for the market are certainly disturbing. One should hope that these are exceptional happenings restricted to the month of July and not necessarily what will emerge as future trends.

The author is retired CMD, Oriental Insurance Company.

The Balancing Act .....continues....

P. S. Prabhakar

(Continued from IRDA Journal, June 2004)

While on Current Assets, a cursory mention needs to be made on 'the most current and the most liquid' item of a balance sheet, which is 'Cash in hand and banks.' Any reader of the financials generally believes what he superficially sees under this item to be true. However, this may not necessarily be so.

This item is largely influenced by the bank reconciliations at the end of the accounting period. The balances that appear are those as per the books of accounts and not as per the bank statements. A statement of reconciliation of balances between the bank statements and the books will always be prepared at the end of the accounting period. And this may contain surprises. There may be scores of items in the said reconciliation under the sub-heading 'Cheques deposited but not cleared' and the chronology may extend to the maximum permitted six months. (Older items are normally in an account called 'Stale Cheques account' and grouped inconspicuously under Sundry Debtors or some such account to finally form part of Current Assets.)

In all such cases, (of the cheques lying uncollected by the bankers, for whatever reasons), the premium income would have been accounted and agency commissions been paid, Sec.64VB compliances would have been certified and perhaps even claims settled! If probed, most of these could be just simple lapses in follow up but in some cases, it could even be deliberate attempts to 'accommodate.'

In the only industry where credit selling is statutorily barred, these lapses are more than just aberrations. Bank Reconciliations made routinely are not supposed to be simple academic exercises but are to be used for probing and following up many items that are between the cup (what is available as per the books) and the lip (what is available as per the bank records). Though it may not be entirely appropriate to expect the insurance companies to include such reconciliations in the financials, it will perhaps be in order for them to make relevant disclosures in the Notes section at least.

There could also be instances of funds that are in the pipeline of the banking channels, where the amounts that have been transferred from one office but are yet to reach the other office of the same company as on the date of the closing of accounts. These are called 'Remittances in transit' and are always grouped in 'Cash & Bank balances,' which, normally will get cleared in a few days time, soon after the new accounting year begins.

However, only very rarely a situation like what happened in a nationalised company for the year ending March 31, 2003, where the statutory auditors had observed that no details were available (on the date of signing the balance sheet, which was a comfortable four months away from the date on which the company closed the accounts) an amount of Rs.400 lakhs shown as 'Remittance in transit.' That this was a very serious irregularity mentioned in a matter-of-fact manner, one which did not even elicit a comment from the CAG auditors or any explanation from the management is, of course, an entirely different matter!

In the only industry where credit selling is statutorily barred, these lapses are more than just aberrations.

Investments

One of the most significant items appearing in the Balance Sheet is 'Investments' and it is indeed very interesting to note how the various components of Investments are represented in Balance Sheets. Most unarguably, an insurance company's major activity is to keep invested its surplus funds at all times and ensure that the returns of such investments are maximised to the extent possible. (Especially, in the recent past, it is only the investment income that is sustaining many an insurance company, with the mainstay occupation viz., insurance, becoming a losing proposition.)

An insurance company's investments are made in different forms such as real estate, government securities, treasury bills, mutual funds, loans to industrial undertakings and very importantly in the capital markets too. The spread normally helps to balance the portfolio between safety, liquidity and returns. (To ensure a judicious spread, there have always been statute-regulated parameters, both in the pre and post-IRDA days.)

In the pre-IRDA scenario, investments were mostly carried at cost in the Balance Sheet without factoring in any possible impairment loss. Only in some extreme situations (like investments in equity of companies which are sustaining losses for three continuous years and whose capital has got impaired or of those companies whose audited accounts not made available etc.), writing down of the values used to be resorted to. Of course, the financials would include a statement mentioning the market values as on the date of balance sheet, more as a disclosure.

However, the post-IRDA scenario saw a sweeping change in the representation of investment values in the Balance Sheet. The Regulations on Financial Reporting made distinct canons in respect of determination of values of different class of investments such as (a) real estate, (b) debt securities, (c) listed securities traded in active markets and (d) unlisted securities and those other than actively traded.

In case of real estate, the historical cost method factored by depreciation and impairment loss, if any will be reckoned. However, the regulations also require the disclosure of the fair value and the basis of its determination.

Debt securities (including government securities and redeemable preference shares) are valued on the assumption of 'holding them to maturity' and hence carried at historical cost.

Before dwelling on the more interesting third category, let us see how the fourth category, which comprises unlisted securities and derivatives and the listed of those but not traded 'actively' is dealt with. Basically these are also carried at historical cost, with provision being made for possible diminution in values. The regulations also permit reversing of such provisions in subsequent periods if circumstances justify, subject of course, to the limits of the historical costs.

The listed securities and derivatives, the regulations say, are to be measured at 'fair value' on the date of the balance sheet. This is where we see a huge departure from traditional reporting methods. The 'fair value' of a security should be its lowest of the last quoted closing price taking into account prices at all the stock exchanges where the security is listed. This, in effect means that the valuation of the listed securities for the purpose of representing in the Balance Sheet will follow the fortunes of the stock markets.

However, the resultant effect of the changes (unrealised gains or losses) between two balance sheet dates, is taken as 'Fair Value Change Account' and grouped under the Equity of the company. In the interests of prudence, the regulations provide that while the favorable balance in this account shall not be available for distribution as dividends, any unfavourable balance shall have to be reduced from profits / free reserves of the company while declaring dividends.

Only when disinvestments are actually made will the profits on such disinvestments which shall include the accumulated changes in the fair value previously recognised, be accounted as revenue in the Profit & Loss account. Till then, the adjustments in the valuation of securities on the basis of the Fair Value will be 'within the Balance Sheet.'

A discerning reader of an insurance company's balance sheet will have to carefully analyse the investment portfolio, study the accompanying schedules (8 and 9), especially with reference to the previous year's figures and also look at that part of the Cash Flow Statement that deals with 'Investing Activities' to find out how the companies have been performing in this crucial area of investments, what kind of securities are being disinvested, how much 'provisioning' is done for impairments, whether the 'Notes on Accounts' carry adequate disclosures on value diminutions or sub-standard assets and how prudently the investment activity has been carried out.

IRDA, as the regulator as well as the custodian of the policyholders' funds, will be very concerned with the way the companies follow the regulations not only in making the investments but also in the adequate reporting in the financial statements.

IRDA, as the regulator as well as the custodian of the policyholders' funds, will be very concerned with the way the companies follow the IRDA's regulations not only in making the investments but also in the adequate reporting in the financial statements. This is because, behind the façade of the seemingly water-tight regulations, insurance companies can still be smart enough to master 'work-around' solutions to ensure they eat the cake and show that they have it too.

Policyholders' Funds

Though it is gratifying to note that the IRDA's regulations on Financial Reporting have, for the first time, given a sort of statutory recognition to the distinction between Policyholders' Funds and Shareholders' Funds, it is indeed perplexing that the format of the Balance Sheet recognises it anything but appropriately. It is common knowledge that the Policyholders' Funds comprise Technical Reserves (Unexpired Risks Reserves of fire, marine and miscellaneous portfolios) and the amounts provided as 'Estimated liability for Outstanding Claims in the aforesaid departments.' For one, the format is designed in a casual manner by including the technical reserves in 'Provisions' along with other provisions like 'Provision for Taxation,' 'Provision for Outstanding Expenses,' 'Provision for Dividend' etc.

Secondly, the other important component of the 'Estimated Liability for outstanding claims' forms part of 'Current Liabilities,' where it keeps company with hazy items like Agents' Balances, Inter-office Adjustments and Balances due to other insurers.

In the humble opinion of the author, it is indeed a pathological error to include both the 'Unexpired Risks Reserves' and 'Outstanding Claims,' together forming part of 'Policyholders Funds" as negative items in 'Application of Funds' in the Balance Sheet. They should have found a separate respectable place in the 'Sources of Funds,' which, indeed, they are. IRDA, in its next revision of the regulations should most definitely consider setting this anomaly right.

With this, the discussion on the major aspects of the Balance Sheet of a general insurance company that need a closer look comes to an end. In the next couple of tranches, let us have a look at the auditors' reporting requirements and also specific issues from the published financials of the insurance companies.

The author, who used to work with the nationalised general insurance industry, is a practicing Chartered Accountant. In this series he discusses the process of analysing the balance sheet of a general insurance company.

RBI PLANS TO RECAP DICGC

Faced with runs in various banks, the Reserve Bank of India (RBI) is reportedly considering options of carrying out a quick fund infusion in the Deposit Insurance and Credit Guarantee Corporation of India (DICGC), whose coffers have been depleted by payouts to depositors of failed co-operative banks. DICGC is an RBI subsidiary which insures deposits of all banks up to Rs One lakh per account.

Since amending the law for fund infusion to the corporation could take some time, the central bank is internally discussing a proposal with the Government, seeking an executive order to recapitalise the Corporation. After repaying depositors of several co-operative banks that failed, DICGC's deposit insurance funds have shrunk to less than Rs. 700 crore.

After peaking to Rs 2,754 crore in 1998-99, DICGC's insurance fund has steadily declined due to the successive failures of co-operative banks. The Corporation raises resources for providing this cover through a mandatory deposit insurance premium collected from all banks. At present, the premium is five paise for every Rs 100 that is insured. The premium enables the Corporation to raise around 0.05 per cent of the assessed deposits of the banking system. DICGC remains a credit insurer only in name, as this part of its business is now defunct.

Since the deposit insurance premium is not enough to generate a surplus, RBI is of the opinion that recapitalisation is necessary until such time that premium rates are increased for weak banks. But the problem is that DICGC — a subsidiary of RBI — is a creation of statute, which has fixed the Corporation's capital at Rs Fifty crore. This means the RBI cannot independently increase the net worth of DICGC by infusing additional funds.

In 1999, RBI had set up a committee to review the position of deposit insurance in India. One of the main recommendations of the committee was to increase the deposit insurance fund of DICGC to two per cent of insured bank deposits.

Last year, when the total deposits stood at Rs 12,13,163 crore, the insured deposits amounted to Rs 8,28,885 crore. This level of deposits will require an insurance fund of Rs 16,000 crore, going by the RBI proposal of having a fund size of two per cent of insured deposits. The requirement will have gone up further, considering that bank deposits have swelled to Rs 15,81,288 crore.

Another proposal of the committee was that the corporation should move away from charging a flat rate to a system where the premium would go up for weaker banks. The strength of a bank was to be determined by the extent of its capital adequacy ratio. The higher the capital, the lower was to be the premium. The committee also wanted that DICGC should be given the right to reject insurance cover for weak banks.

FOR SMALL BUSINESSES AGAINST DISASTERS

The Gujarat-based Disaster Mitigation Institute (DMI) has announced a new insurance scheme for small businesses to protect them from disasters like floods and earthquake, it is reported.

Named 'Afat Vimo' or disaster insurance, the scheme has been launched as a risk transfer product by the institute set up in early 1990s. The self-financing scheme will cover 1,000 victims of disaster in the initial stage.

"Risk transfer initiative is about identifying a vulnerable community, pooling its risks and transferring it to those who are not vulnerable to the same risks and can absorb them," said the institute's director Mr. Mihir. R. Bhatt is reported saying.

"The scheme is aimed at insuring poor and small businessmen against loss of work, life, shelter and other damages," Mr. Bhatt said, adding that India loses up to two percent of its gross domestic product and 12 per cent of its revenues each year to natural disasters.

"The Calamity Relief Fund of the Indian Government spends Rs.12 billion each year towards relief to the victims of disasters, but the idea of insurance against disasters is not common," he said.

'Don't merge PSU general insurers'

Consultant AF Ferguson may oppose the view that the four state-owned insurance giants should be merged, it is reported. Ferguson's forthcoming report, expected by the end of the month, will thus oppose the merger idea put forward by Parliament's standing committee on finance.

The report, it is said, will instead focus on internal restructuring of these companies.

In its report last year, the standing committee had suggested the merger of the four state-owned general insurance companies, United India, Oriental Insurance, New India Assurance and National Insurance.

The report would also form the basis for undertaking wage revisions. Promotions have been stalled despite an eight per cent drop in workforce due to voluntary retirements.

The finance ministry had appointed AF Ferguson in May to prepare a report on the four PSUs.

LAW SOON TO REGULATE CLINICAL ESTABLISHMENTS

The Health Ministry is planning to come up with a legislation that will certify and set standards for clinical establishments, it is reported.

Senior officials in the Ministry have been quoted saying that a new Bill called the Clinical Establishment Regulations Act is in the offing. The Bill will have provisions for registration of hospitals, clinics and diagnostic centres. It will ensure standardisation of procedures and also push for accreditation of healthcare centres. A certifying authority could also be set up under the new law.

The Health Minister, Dr. A. Ramadoss has also made it clear that the accreditation and standardisation of such institutions is top of the agenda. "Unless there is uniformity in standards and a comparable price structure among healthcare centres offering similar services, neither will health tourism nor insurance take off. Hence, the need for a legislation," said the Ministry officials.

Meanwhile, the Confederation of Indian Industry's (CII) National Committee on Healthcare, in its last meeting, has also said that hospital accreditation should very quickly become a reality. India has the potential to attract one million tourists per annum, which could contribute as much as $ five billion to the economy, said the chamber.

However, healthcare industry analysts are reported saying that hospitals are not willing to open up their books for scrutiny by external agencies. "There is a reluctance among hospitals to show their financial accounts or even permit hospital visits. Unless they do so, it will be difficult to rate these institutions," said analysts.

LIC SET TO ENTER FIVE NEW COUNTRIES

Life Insurance Corporation of India (LIC), which has targeted five per cent of its premium income from overseas operations, is set to enter five new countries, it is reported.

"We plan to enter countries such as Maldives, Botswana, Seychelles, Madagascar, Trinidad and Tobago Islands," Mr. R N Bharadwaj, Managing Director, LIC is reported saying.

"We have already set up operations in Mauritius and would initially service and acquire clients in Botswana, Seychelles, Madagascar and Maldives through our Mauritius office. If we are able to capture enough business in these two countries, we would go for joint venture operations in all these countries where we intend to be large players," he said.

"Initially we would appoint brokers and agents to cater to clients in these areas," he said. Talking about Trinidad and Tobago Island operations, Mr. Bharadwaj said it would be services and catered from the Fiji office which LIC had opened sometime back.

LIC was also considering a sizable stake of the European market from the London office. "We have started operations in the UK sometime back and would like to cater to European countries from there," he said.

The same formula for opening up of companies in these countries would apply, depending on the volume of business LIC manages to do.

BRITISH SURVEY FINDS INDIAN CALL CENTRES SATISFACTORY

Reporters of a British newspaper conducted a survey on the performance of insurance major Norwich Union's call centres in India and found them not only to be satisfactory but also cost-effective.

The snapshot survey was done by reporters of the Eastern Daily Press, and involved calling up numbers of the Norwich Union and its main competitor Churchill, a part of the Royal Bank of Scotland group.

Norwich had sparked controversy when it transferred thousands of Britain's jobs to new call centres in Bangalore and New Delhi. Customers said Indian staff were hard to understand and did not have enough knowledge of the UK motor industry.

In letters to the newspaper, customers had complained of being left hanging on the phone, of impenetrable accents and having trouble with straightforward queries.

For its part, Norwich said the performance of its Indian operations has been as good as its British sites.

For the survey, the newspaper's team of reporters dialled NU Direct to get a car insurance quote, followed by another to either Churchill - which has all its call centres in Britain - or a similar insurance provider.

Some calls were directed to Norwich's call centre staff in India and others to Glasgow or Liverpool.

All the reporters succeeded in getting quotes without much trouble, although the costs sometimes varied wildly - in one case from £555 to £1,068 for the same level of cover.

The consensus was that calls to Norwich's Indian centres could take a long time, with several misunderstandings over language and accents proving hard to decipher at times, but information did come by.

Indian call centre staff seemed eager to please by offering cut-price rates and free products thrown in.

The reporters found that young graduates, keen to sell large numbers of policies to new and existing customers, mainly staffed Norwich's Indian call centres.

NU customer service director Simon Machell said the company had not seen a noticeable rise in complaints since the Indian call centres came on line.

"As our Indian workers are getting more experienced, they are getting better at handling the calls, although we do not let them on the phones unless they can have an acceptable conversation with the customer. We're very happy with how the Indian centres are performing."

Best Upgrades Lloyd's Rating to 'A'

A.M. Best Co. announced that it has upgraded Lloyd's financial strength rating to "A" (Excellent) from "A-" (Excellent), and has assigned an issuer credit rating of "a" with a stable outlook.

Lloyd's management welcomed the decision as underscoring the financial strength of the London market. In the wake of the decision Best also took a number of rating actions on individual Lloyd's syndicates.

"The rating reflects Lloyd's improving prospective capitalisation, strong operating performance, its global reach and improvements in risk management," said Best. The report noted, however, that a "partially offsetting factor is Lloyd's exposure to long-term uncertainty relating to the adequacy of Equitas' reserves. But Best said it thought it unlikely that this would adversely affect Lloyd's in the near term.

Best said it "believes the absolute level of central solvency capital (including the net assets of the Corporation of Lloyd's, the Central Fund and the callable layer) is likely to be increased to approximately GBP 2 billion (USD 3.7 billion) between 2004 and 2008. Over this period, as part of Lloyd's underwriting cycle management strategy, underwriting capacity will most likely be reduced if market conditions continue to deteriorate."

The rating agency added that it anticipates that "other sources of finance will be used to enhance central capital addition to members' contributions (currently charged at 1.25 percent of capacity and paid into the Central Fund)."

It also indicated that the rating "reflects A.M. Best's expectation that growth of the Central Fund is unlikely to be materially affected by reserving issues relating to U.S. casualty business written between 1997 and 2001. In addition, Funds at Lloyd's requirements for members are likely to increase as a result of likely upward pressure arising from application of the risk-based approach to capital developed by the U.K. Financial Services Authority (FSA)."

Best cited Lloyd's strong operating performance, noting that it "believes that Lloyd's loss ratio development (including paid and outstanding claims) supports pure year results for the open 2002 and 2003 years of account above Lloyd's current estimates of GBP 1,670 million (USD 3,053 million) and GBP 1,780 million (USD 3,254 million)."

For 2004 Best said it "expects substantial earned premium derived from the 2003 underwriting year and continuing good market conditions for Lloyd's specialist classes to support a combined ratio close to the 2003 level of 89.2 percent and a profit before tax of approximately GBP 1.9 billion (USD 3.5 billion) (subject to catastrophe experience in the second half of the year)." It also "believes a combined ratio below 95 percent is likely to be achieved in 2005, despite some deterioration in loss ratios as rates reduce in a softening market."

In conclusion Best said it "believes that Lloyd's now has a clearer focus on its downside with detailed performance analysis; increased sophistication in capital modeling; a clear strategy for claims and reinsurance recoveries; management of open years and syndicate run-offs, all contributing to an enhanced risk management environment."

TATA TO DEVELOP ISLAMIC INSURANCE SOLUTION IN MALAYSIA

TATA Consultancy Services (TCS) said it has been awarded a project worth RM$8.7mil to build and develop a comprehensive Islamic insurance solution, called Takaful Integrated System, for Syarikat Takaful Malaysia Bhd.

Under the terms of the contract, the two companies will work together to develop and bring the system to Takaful Malaysia's subsidiaries, branches and associates in South Asia and the Middle East, as well as other takaful operators in the Islamic insurance business.

The new system is expected to be fully operational by mid-2005, TCS said in a statement.

The Takaful Integrated System will be built on a J2EE (Java 2 Platform, Enterprise Edition) architecture and will automate Takaful Malaysia's business processes, such as policy administration and claims processing.

Takaful Malaysia is the first operator to offer takaful businesses in Malaysia and was established from recommendations given by the Malaysian Government's Special Task Force on the "Study for the Establishment of an Islamic Insurance Company (Takaful)."

J.D. POWER STUDY:
SATISFACTION HIGH FOR AUTO INSURANCE CONSUMERS USING THE INTERNET

A small but growing group of customers are turning to the Internet rather than phone calls or office visits to communicate with their auto insurance provider, according to J.D. Power and Associates' 2004 National Auto Insurance Study.

While only seven per cent of consumers are using the Internet to check on or update their auto insurance policies, their satisfaction is higher than those who use an automated phone system. In addition, their satisfaction is only slightly lower than those who talk directly with their insurance agent or representative.

"The Web represents a highly efficient communication channel," said Mr. Jeremy Bowler, director of the insurance practice at J.D. Power and Associates. "It's surprising that very few carriers appear to be successfully promoting its use for servicing customers."

The study also finds that younger car insurance buyers are fueling the expansion of Internet insurance shopping. Forty-two percent of shoppers under 30 used the Internet to shop for auto insurance, compared to 29 percent of all shoppers.

"Insurance providers that are looking to attract new, young buyers, have to better integrate the Internet communications channel," said Bowler.

New for 2004, the customer satisfaction index reveals that the customer experience is driven by five factors: interaction with the provider; billing; policy offerings and initiation; cost; and claims. However, while only a fraction of consumers filed a recent claim, those who have tend to be significantly more satisfied with their carriers than those who have not filed a claim.

"The claims experience is the moment of truth that drives a customer's overall impression of their insurer, as well as their loyalty," said Bowler.

Overall customer intent to renew their policy with their current carrier is at a four-year high and the likelihood to refer their provider to others has recovered to a level last seen in the 2001 study. Despite these high loyalty rates, nearly one-third of consumers, many spurred by a rate increase, report that they have shopped for a new provider in the past year. More than one-half of those who shopped went on to switch their provider.

The 2004 National Auto Insurance Study is based on 13,944 responses from auto insurance policyholders.

IMF URGES PAKISTAN TO IMPROVE INSURANCE SECTOR

The International Monetary Fund (IMF) has reportedly asked the Government of Pakistan to clearly demarcate responsibilities of the ministry of commerce and the Securities Exchange Commission of Pakistan (SECP) for effective regulation of the insurance sector in the country.

"The IMF has suggested that the regulatory and supervisory responsibility for insurance should lie with the SECP and that oversight relating to ownership and governance of the public sector insurers should rest with commerce ministry," an official source was quoted saying in the Daily Times.

The IMF has suggested to the government that future of the three public sector insurers also needs to be reviewed. "The IMF is of the view that there appears little benefit in maintaining the government monopoly of National Insurance Company (NIC) and the authorities should consider developing an exit strategy," the official said.

The IMF has suggested that it is also highly desirable that the government limit its exposure to contingent risks entailed by Pakistan Reinsurance Company Limited (PRCL), possibly by finding a private sector partner.

"However, the IMF has suggested that given its (government) central role of the State Life Insurance Company (SLIC) in mobilising funds for long-term investment, some form of arms-length ownership that does not distort the contractual savings market would be justifiable."

The official said that the IMF is of the view that the insurance sector in Pakistan is highly underdeveloped. Insurance premiums per capita of $1.0 for life and $1.7 for non-life in Pakistan is extremely low if compared with $11.3 and $3.0 for India and $5.2 and $6.6 for Indonesia.

The Fund management has observed that the Insurance Ordinance 2000 has introduced a number of laudable reforms, but has also omitted a number of elements that are key to a modern risk-based supervisory regime. The latter include limited prompt corrective action power, lack of onsite supervision capacity and in-house specialist skills.

ROUND-UP

REGULATORS DO HOMEWORK

The Annual Seminar on Regulatory issues for senior officers of insurance regulatory agencies was held in Delhi on July 15 and 16. It was organised by the Institute of Insurance and Risk Management (IIRAM), IRDA, United Nations Conference on Trade and Development (UNCTAD), National Association of Insurance Commissioners (NAIC) and the International Association of Insurance Supervisors (IAIS). Officials from insurance regulators' offices in over 20 countries participated.

L to R: M.r C. S. Rao, Chairman, IRDA, Mr. Nigel Easton, UNCTAD and Mr. Yoshihiro Kawai, Director General, International Association of Insurance Supervisors (IAIS).

BROKERS MEET

The first meeting of the members of the Insurance Brokers' Association of India (IBAI) was held in Hyderabad on July 31. A one day seminar on "Insurance Brokers: A Way Ahead" was conducted.

L to R: Mr. C. S. Rao, Chairman, IRDA is welcomed with a bouquet by Mr. Bharat J. Boda, President, IBAI.

Looking ahead 10 years, I firmly believe that the most successful, least crisis-prone businesses will be those whose boards have shown firm resolve and taken decisive action. Effective, integrated strategies for dealing with tomorrow's risks require a change in culture at board level now.

Lord Peter Levene, Chairman, Lloyd's of London

We had security analysts at all the Athens ports six to seven months ahead of time going through security issues ad infinitum. They came up with hundreds of recommendations because there basically wasn't any security before they arrived.

An underwriter commenting on the insurance cover for Athens Olympics which has broken the record with over $ 1 billion worth insurance coverage.

The Web represents a highly efficient communication channel. It's surprising that very few carriers appear to be successfully promoting its use for servicing customers. Insurance providers that are looking to attract new, young buyers, have to better integrate the Internet communications channel.

Mr. Jeremy Bowler, Director, Insurance Practice, J.D. Power and Associates about a US study showing that younger car insurance buyers are fueling the expansion of Internet insurance shopping.

A number of coverage gaps are widening as risk is shifting to individuals... Further, it will only increase as many nations struggle with the high cost of aging populations...Traditional products sold via traditional agent channels have become too expensive for the mass market.

Mr. Mike Kostoff, Executive Director, Corporate Executive Board's financial services practice on a study on the profitability of mass insurance markets.

Since, it's a sunrise industry, a lot of people just want to join the race, but cannot retain the enthusiasm till the end of a year.

Mr. Shivaji Dam, Managing Director, Kotak Life Insurance on the high attrition rates in the industry reported to be between 14 and 38 per cent.

...the growth in the health insurance sector has been extremely unsatisfactory.

Mr. T. K. Banerjee, Member (Life), IRDA

RNI No: APBIL/2002/9589

Events

4 - 8 September 2004
Venue: Monaco
Monte Carlo Rendezvous

6 - 11 September 2004
Venue: Pune
Data Warehousing and Data Mining by National Insurance Academy (NIA)

13 - 18 September 2004
Venue: Pune
Insurance Management of Infrastructure Projects by NIA

13 - 18 September 2004
Venue: Pune
Research Methodology and Market Research by NIA

13 - 14 September 2004
Venue: Pune
C.D.Deshmukh Seminar on Agenda for Growth of Insurance Industry by NIA

11 October 2004
Venue: Mumbai
Seminar on Directors' & Officers' Liability: Trends, Risk and Insurance in a Changing Landscape organised by Institute of Insurance and Risk Management, Hyderabad.

18 - 19 October 2004
Venue: Agra
Third International Symposium on New Technologies for Urban Safety of Mega Cities in Asia organised by Indian Institute of Technology (IIT), Kanpur, and International Center for Urban Safety Engineering, Institute of Industrial Science, University of Tokyo, Japan

27 - 29 October 2004
Venue: Hyderabad
A Billion Lives to Cover: Working together to expand Health Insurance in India organised by USAID, IRDA and Bearing Point.