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NICHE MARKETS

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From the Publisher

The road less trodden is not so much a choice but a necessity in journeys into the unknown. For an industry that is rediscovering itself and its markets, ventures into distant rural markets and even niche urban markets have been quite an experience.

This issue of **IRDA Journal** carries a cross section of articles on alternate channels of distribution. While agents are, and are likely to be, the predominant channel for selling life insurance and personal lines of non-life insurance, other means of reaching the customer also assume importance given the low levels of penetration of insurance in India.

I have no doubt that everyone in the insurance industry would like to see the country reach the levels of financial security through insurance that more developed countries have. And I am sure that this aspiration is not only driven by commercial interests but also the aspiration for better social security and prosperity. For taking that kind of leap every effort counts and every new idea that can harvest a few thousand customers will help. One never knows which of these new channels will turn out to be a significant contributor of customers tomorrow!

And while the industry looks at new ways to sell insurance we also take a close look at the systemic and legal questions that arise, which companies are no doubt tackling methodically.

This topic brings to a close three intertwined topics related to products and the customer. Customer expectations, new products and alternate channels to reach the customer.

The next issue will focus on an entirely new sector that is thought to be one of the highest potential sunrise industries that the country will see. Pensions.

Until now the market for pensions has seen limited attention from the financial service providers who offer retirement solutions, including life insurance companies.

It is widely believed that the future belongs to retirement solutions. Insurance companies are closely involved in this activity in that life insurance companies have a monopoly on the provision of annuities. They could be involved in other activities in the chain that constitute retirement solutions as well as per the policy proposals before the Government.

The Journal has been bringing you snapshots of the changes in the pensions sector in the last two issues. Next month we will take an extensive look at how the pensions markets have been and how they are likely to be in the future.

C.S. Rao

C.S.RAO

Inside

ISSUE FOCUS

Finding its own way...

In this issue we bring you the third of a set of topics related to customers and products. Customer expectations, new products and now, alternate channels of insurance distribution.

Taking agency, corporate and individual, brokerage and bancassurance all as traditional channels, we have tried to see what new channels for marketing and distributing insurance have been adopted by the industry.

And with the new channels have come new challenges to overcome. We present you some perspectives on that as well with a view to discussing what shape these new channels could take in the future.

A feature gives you a cross section of what companies and the channel partners themselves are doing differently. While ITC's e-Choupal initiative is widely known and its success acknowledged there are smaller but equally commendable initiatives that are elaborated on here. Also our Legal Officer takes a look at the stand of the Law on some issues like data privacy in the case of database selling, and e-commerce present.

We bring you Mr. G. V. Rao's piece asking whether the industry has exploited the capabilities of the existing traditional channels fully or not while Mr. V. Krishnan of Tata AIG General Insurance Company looks at the presence of alternate channels internationally and in his own company that issue marine cargo policies on the Internet.

Our End User section, which sometimes starves for want of good writers passionate enough about consumer issues, has had an old faithful in the indefatigable Mr. H. K. Awasthi of Consumer Voice who closely follows consumer forum judgements and translates them into lessons learnt (or yet to be learnt) for the insurance industry. He writes about two significant cases pertaining to consumer fora and compensations this time.

This is one section that can never have too many writers according to us, and so, readers, if you are so inclined, write to us about consumer related issues. Whether it is your experience, good or bad, with the vagaries of insurance or at the hands of insurance companies, or your expert comment on things related to consumer interest and insurance wrought through your own experience, write for us!

Those of you who wrote in on the width of Mr. M. Arunachalam's piece on Technology and the Indian Insurer will find that he takes you into another dimension of the issue in the second part of his article. For those of you joining us now, the last issue carried a prelude about the current status of technology usage in the Indian insurance industry and the potential of IT in an information intensive industry such as this.

We interrupt our series on balance sheet analysis of general insurance companies by Mr. P. S. Prabhakar in the column Keeping Count while he takes a break, and start what will hopefully be a parallel series, this one on taxation of life insurance companies by Mr. G. Saikumar of the IRDA team who, too, makes a debut!

You will find a larger section of Pension Page this time. Not without reason. We have extracted the discussion paper that gives the qualifications and procedure for the licensing of pension fund managers (PFMs) who will operate in the Pensions sector.

We are also laying the ground for our special issue on Pensions in July.

We hope you find this issue interesting, and hope to hear from you about it. As always, criticism is more welcome than any other form of feedback so that we can keep a close watch on what our readers want.

K. Nitya Kalyani

Looking to the Future

K. Nitya Kalyani

Our forefathers set out four phases in the life of a human being. There was a time to learn, to earn, to marry and have a family and then, a time to give it all up and prepare mentally, spiritually and emotionally to leave this world.

They lived in a gentler, simpler time where renunciation and a retreat into a life of contemplation was the ultimate sophistication.

How ironic that we, today, have to get more acquisitional to be able to get to renunciation!

But that is the truth and we have to prepare for it – every one of us. The society is beginning to prepare for it collectively too. The pensions industry is being revved up and reformed so that it will serve as the means for a generation to start preparing for its retired life.

That is the focus of our next issue.

It is not that our security conscious, resource poor people did not want pensions. It was not that the demand was not there. Just the rush for government jobs in the last 50 years (and before it too) is enough proof that the pension (and job security) was the prime motivator. And the government job pension terms are generous by today's standards.

Defined benefit – which means your pension amount is fixed depending on your salary at retirement, never mind whether your pension contributions can pay for it or not – is gone and, in its place, from January 1, 2004 has come defined contributon (where you know how much you have to sacrifice from your salary each month, but there is no certainty about what nest egg it will lead to at the time of retirement.) This does not apply to those joining the armed forces. In course of time state government and public sector employees will also be allowed to join the new pension scheme, as

Such uncertainty is the result of the changes the investment market is seeing after liberalisation. The

> We, today, have to get more acquisitional to be able to get to renunciation!

Government too has had to heed the call for efficiency and cut back on its tendency to build up its liabilities. This financial caution cannot but be mirrored by state governments and government undertakings.

Will this take the sheen off The Government Job? Doubtlessly, but it was an artificial sheen, some would say, amplified by an atmosphere where opportunities were relatively hard to come by. Compare this with the past decade where education and jobs have opened up new avenues for the young, at least in the urban areas and among the middle classes.

And see this along with how people are living longer, how everything, including medical care is costing more, and how people prefer to live their own lives out of choice and we can see how another layer of stress is added to the earnings stream of an individual today. That of having to earn for his retirement as well.

But just earning will not cut it, and so enters saving for retirement, and buying insurance against the chances of living too long. That is what an annuity is. An insurance policy that bears the risk of your living too long. And undertakes to give you a regular income for life. That is the last link in the chain of funding your retirement. Regular savings, investment of those savings, using the accumulated sum to buy an annuity... all those are what the retirement planning industry will be all about.

In the next issue we hope to bring you the policy status regarding this sector, recent moves at reform, and an idea of what the market means qualitatively and quantitatively to the society.

Please do join us with your opinions and experiences. They are always welcome.

Let's talk
about pensions.
In the July Issue.

Bonus only out of Surplus says IRDA

IRDA has cautioned life insurance companies against the practice of declaring bonus to the policyholders except out of an actuarial surplus following valuation. This surplus shall not be increased by contributions out of any reserve fund or otherwise unless they have been brought in through the Revenue Account on or before the date of the valuation, says a circular to life insurance companies from the regulator. The above procedure is as per section 49 of the Insurance Act, 1938.

It had been observed that companies have taken recourse to Shareholders' funds in different ways to enable declaration of bonus to participating policyholders.

Where the life fund is in deficit and a life insurer intends to declare bonus, the IRDA has stipulated certain conditions. They include:

The insurer shall make good the accumulated deficit in the Policyholders' Account and also transfer adequate assets to cover the cost of bonus prior to declaration of bonus to the participating policyholders.

The transfer should be authorised through a special resolution of the shareholders at the general meeting of the insurer and shall be irreversible and be fully backed by transfer of assets/investments to the Policyholders' Funds and should be adequate to meet the policyholders' liabilities including the cost of bonus.

This is further subject to the condition that as a result of the transfer the insurer shall appropriately increase the paidup equity capital.

The proposed rates of bonus should be sustainable over the future.

The IRDA has stipulated that life insurance companies who have not conformed to the above requirements – which are available to them only for the first five years of their operations – should ensure compliance with retrospective effect while finalising their accounts for the financial year 2003-04.

BROKER SUSPENDED

IRDA has, on May 5, 2004, temporarily suspended the Licence granted to M/s Avani Insurance Services Pvt. Ltd., a composite insurance broker.

The action follows the shareholding of the company having been acquired by Berger Paints India Ltd. without prior information to the Authority, thus placing the Authority in a position where it was unable to ascertain that the new shareholders of the brokerage company were capable of fulfilling the conditions of holding a license as specified under IRDA (Insurance Brokers) Regulations, 2002. This lack of information is detrimental to the interests of the policyholders.

The suspension would last till such time the new shareholders i.e. M/s. Berger Paints India Ltd. satisfies the Authority that they would be able to fulfill all the requirements as stated in the regulations referred to above. Also, they would not be entitled to payment of any remuneration for the insurance broking activities carried out w.e.f. 25th March, 2004, the date of their letter informing the Authority about the change in shareholding.

MAINTAIN RESERVE FOR PREMIUM DEFICIENCY

IRDA has allowed Non-life insurers to provide for premium deficiency for the three major segments namely, Fire, Marine and Miscellaneous and not segmentwise as was required. Any premium deficiency in these three classes of business has to be provided for by the insurer irrespective of there being no deficiency on a global basis says a circular from IRDA.

The IRDA (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002 stipulate that premium deficiency shall be recognised if the sum of expected claim costs, related expenses and maintenance costs exceeds the related reserve for unexpired risks. Provision has to be made for the premium deficiency in each individual segment.

Companies had represented to the IRDA that they be allowed to do this reserving on an overall basis rather than segmentwise following which a relaxation has been made.

As per regulations disclosure of the deficiency in each sub-segment of insurance business should be made in the Notes to the Accounts. In addition, deficiency in respect of any reportable segment which contributes 10 per cent or more to the premium of the insurer is also to be separately disclosed and the method of computation of the deficiency should be available for scrutiny by the Authority.

The objective is to ensure that the insurance company maintains a Reserve for Premium Deficiency to take care of a situation where premiums are not sufficient to meet claims, present or future.

TRAINING INSTITUTES RESTRAINED

IRDA has restrained four of its accredited training institutes, NIS Sparta Ltd., Taurus Institute of Insurance Training, IL & FS Educational Services and Vision Insurance Academy from conducting training programmes and has advised them not to take any new batches.

The action followed the discovery during surprise inspections by officers of the Authority of some IRDA Accredited Insurance Agents training institutes between April 19 and 23, 2004, when it was found that some centres of these institutes were not having the mandatory infrastructure facilities as required by the conditions of accreditation.

An enquiry is being conducted in the matter and the institutes have been restrained from carrying on training activities pending final outcome of this enquiry.

Managing Pension Funds

- An Overview of the Proposed System

In this new section we will keep track of what is happening in the pensions sector which is poised for policy changes. In the last issue we saw the proposed structure of the pensions market with a Central Recordkeeping Agency (CRA), Pension Fund Managers (PFMs), Points of Presence (POP) where you can open a Personal Retirement Account (PRA) or make subscriptions to it, Annuity Providers (AP) and Authorised Retirement Advisors (ARA).

The newly formed Pension Fund Regulatory and Development Authority (PFRDA) has a new Chairperson in Ms. Vineeta Rai who is Revenue Secretary Union Finance Ministry.

The PFRDA will regulate the activities related to the pension industry and all its participants. The first step that has been taken is that the Union Government employees (except those in the armed services) who join service from January 1, 2004 will come under the new system of Defined Contribution (DC) pension rather than the Defined Benefit (DB) pension that has been in force for decades now.

They can, through their employer, open PRAs and choose from different PFMs and the three standard investment schemes that each PFM will offer, namely Growth, Balanced and Safe, each reflecting the investment mix of the fund. Members can switch between PFMs and investment schemes at will. At a later date state government employees and public sector unit employees will also be allowed to join the scheme and so will workers in the private sector, the unorganised sector and the self-employed.

Expressions of Interest have been called for to set up PFMs, which are likely to be limited in number to begin with. What follows is an outline of the qualifications for entering the bid and the process that is envisaged for the selection.

The Invest India Economic Forum (IIEF), which has been advising the Government on pension reforms has put out a discussion paper about PFMs wherein the policy options for limitation or otherwise of the number of PFMs has been outlined as also the policy and operational framework for PFMs. The full document is available at IIEF's website on www.iief.com.

As the IIEF says in the paper: *This document evaluates the various policy options and outlines a draft operational environment and selection process for PFMs. Public comments, inputs and ideas on this document from domestic and international experts are invited and will be carefully considered and evaluated by the Government while drafting the final policy framework for PFMs including the detailed investment guidelines, performance measurement process, operational and functional obligations, eligibility criteria and selection procedures, etc.*

Extracts:

Policy questions and alternatives

The primary concern of policymakers will be to provide an environment for members to maximize their retirement benefits in a fraud-free environment. As a result, stringent entry and selection criteria for pension asset managers with adequate asset management experience and capabilities, standardized and regular information disclosure, effective supervision of investment processes and strict adherence to prescribed investment and business rules will be of paramount interest to policy makers.

Competition between fund managers is widely viewed as a highly desirable feature of the pension sector. Standard, simple and regular disclosure of performance, fees and costs, in an environment where fund managers compete to attract pension assets, offers two key benefits to members – (a) it provides a powerful motivation for efficient management of retirement savings, and (b) it lowers asset management costs.

The PFRDA proposes to appoint competing professional pension fund managers (PFMs) for this system. These PFMs will be allowed to offer their services for managing the retirement savings under the new pension system. These PFMs may also be allowed to offer fund management services to other pension, PF and retirement plans in the country.

The Government and the PFRDA are evaluating several policy choices and questions which will have an important bearing on the incentives, performance and actions of pension fund managers and hence on member benefits. Some of these questions and choices include:

Expressions of Interest have been called for to set up PFMs, which are likely to be limited in number to begin with.

Should the number of PFMs be limited?

The number of PFMs that participate in a pension system with individual accounts will have an important impact on coverage, charges and benefits. Countries with a large number of pension fund managers have experienced the following issues with governance and customer service:

1. More PFMs pushes up fees as they spend more on marketing and sales.
2. More PFMs means more confusing choices for individuals which may deter them from readily entering the system;
3. The problem of enforcement and prevention of fraud is larger with a large number of pension fund managers.

There are also some weaknesses in a system with a very limited number of PFMs.

These include:

1. With fewer PFMs, some may become too big to fail (TBTF) and turn into problems for the State.
2. The problems of potential collusion between a handful of PFMs;
3. Mergers amongst an already limited number of PFMs may lead to a dampening of competition;
4. A few PFMs may not be able to cope efficiently with millions of potential members; and

5. Political pressures from a limited number of PFMs may lead to a continuation of the restrictions on entry of more players.

From a PFM's point of view, a limited number of competitors for a specified period provides a larger (and perhaps guaranteed) market share and makes the pension fund management business more attractive in the short term. Also, as the estimated size of assets in a new pension system is likely to be small in the initial years, it may be prudent to (initially) limit the number of PFMs.

Fresh applications from new, prospective PFMs can be invited when some system milestones are achieved.

How can the number of PFMs be limited?

If the Government and the PFRDA decide to limit the number of PFMs in the new pension system, this decision can be implemented through the selection process. A limited number of PFMs can be selected using either of the following process:

1. auction of a limited number of PFM licenses, or
2. self selection and approvals based on prescribed eligibility criteria

Should existing or only new firms serve as PFMs?

There are no existing entities which are registered as pension fund managers in India. It is likely that domestic and foreign banks, financial institutions, asset management companies, insurance firms, NBFCs, etc. will be interested in the newly opened pension fund management business. A decision regarding the structure and ownership of PFMs is essential as it will have an important bearing on their operations, costs and governance. The two approaches that policymakers can consider in this regard are:

(a) allowing existing firms to serve as PFMs

(b) allowing only specialized, new entities to serve as PFMs

In general, allowing existing entities to serve as PFMs can cause cross subsidies between pension and non-pension assets, spillover of risks between pension and nonpension businesses, as well as regulatory overlaps leading to potential conflicts and governance inefficiencies. On the other hand, establishment of new entities will increase the cost of pension fund management. Most countries across the world have chosen the route of establishing new dedicated pension fund managers. However, there are also instances (as in the case of Sweden) where existing asset management firms have been permitted to offer pension scheme which are subject to some additional regulations and reporting obligations.

As the estimated size of assets in a new pension system is likely to be small in the initial years, it may be prudent to (initially) limit the number of PFMs.

Proposed operational and policy framework for PFMs

India's policymakers may choose to derive their conclusions and frame an appropriate policy direction for PFMs also on the basis of the following core objectives of this new pension system for India:

a) **Simplicity**: This pension system is targeting over 300 million workers with low literacy, low levels of financial literacy, diverse demography, savings capacity and attitudes towards retirement, risk and savings. To achieve significant voluntary coverage, this pension system should be very simple and easy for ordinary people to understand.

b) **Nationwide access**: A key aspect for driving coverage will be the ease with which consumers spread across 3.3 million square kilometers will be able to participate in this pension system.

c) **Consumer choices and rights**: A mix of three simple products (safe, balanced and growth) and the 'default' option for people who are unable to take a decision will be able to cater to persons of every age, education, income or risk profile. In addition to offering a limited number of standard products, the system should make it easy for a member to exercise his choice and empower each member to alter his or her allocation with changes in age, income, risk profile, etc. with the least cost and administrative overhead.

d) **Low fees and charges**: Fees and charges on assets have a significant impact on terminal accumulations and are thus of special interest to policymakers.

e) **Maximum returns**: Retirement savings can be maximized through a variety of prudent strategies including (a) investment into equities with some international diversification, (b) competition between multiple PFMs, and (c) regular reporting of fees and performance in a standard and simple format to customers.

f) **Sound governance**: Proactive regulation and sound governance will be essential to protect the interests of each consumer in India's pension sector over multiple decades.

The following sub-sections provide the outline of a draft policy framework for PFMs under this new pension system.

Operations and restrictions for PFMs

1. Each PFM will offer *three standard schemes or products* – which can be broadly categorized as 'Safe', 'Balanced' and 'Growth'. In each of

Indicative investment guidelines for the three schemes

% of portfolio

Type of Investment	Safe/Default	Balanced	Growth
Government Paper	>50	>30	>25
Corporate Bonds	>30	>30	>25
Domestic Equity	<10	<30	<50
Of which, International Equity		<10	<10

these three schemes, PFMs will be able to invest (as per the investment guidelines prescribed by the PFRDA) in equity, corporate debt and government bonds. The allocation in each asset class may not be rigid and instead based on 'bands' prescribed by the PFRDA. Some international diversification under each asset class shall be permitted. The investment guidelines proposed under the Project OASIS Report are provided above which may serve as an indicative guide on asset allocation to potential PFMs:

Only *passive investment* (using a PFRDA approved index) will be permitted for all domestic and overseas equity investments under each of the three products.

5. PFMs will be able to undertake *sales, marketing and communication activities* to encourage new members to join the system and existing members to optimize their allocation across the three schemes.

Broad pre-qualifications and pre-conditions for PFMs

1. PFMs will be new, separate entities which will be required to be registered with the PFRDA. These PFMs will offer pension fund management services based on investment guidelines prescribed by the PFRDA. Only these registered PFMs will be permitted to manage the assets under the new pension system and of other retirement schemes which are under the jurisdiction of the PFRDA.
2. PFMs will be granted a license by the PFRDA on the basis of a competitive and transparent bidding process. This process of granting licenses as well as the proposed license terms and conditions for PFMs are described in more detail in the subsequent sections.
3. Initially, the PFRDA will issue six PFM licenses. One (1) of these six PFMs will be a publicly owned, domestic public sector PFM.
4. The PFRDA will issue the seventh PFM license when the total assets under management (AUM) of the pension system becomes Rs.15,000 crore. Thereafter, a fresh PFM license will be issued whenever the AUM of the system grows by Rs.2,500 crore. The criteria for granting new PFM licenses on the basis of AUM growth will be regulated (and may be changed over time) by the PFRDA.
5. The following categories of firms will be allowed to sponsor a new pension fund management company and bid for a PFM license:

> Only passive investment (using a PFRDA approved index) will be permitted for all domestic and overseas equity investments

a) *Domestic mutual funds* registered with SEBI with an AUM of Rs.4500 crore on the date of bidding

b) *International mutual funds, pension funds or insurance firms* with an AUM of Rs.1,00,000 crore and experience of minimum 20 years in financial services

c) *Life insurance firms* registered with the IRDA before December 2003

d) *Domestic or foreign banks or financial institutions* registered with the RBI with a minimum investment portfolio of Rs.4500 crore.

6. A bidder for a PFM license with majority shareholding by a domestic firm will be considered a *domestic bidder* and will need to satisfy the eligibility criteria (AUM, experience, etc.) for domestic firms. Similarly, a bidder for a PFM license with majority shareholding by an international firm will be considered an *international bidder* and will need to satisfy the eligibility criteria (AUM, experience, etc.) for international firms.
7. An international firm which decides to sponsor a PFM and bid for a license will be allowed to participate in the bidding process without setting up an office in India.

   However, if the firm is granted a license to set up a PFM, it will be required to incorporate a company in India. This may be set up as a 100 per cent subsidiary of the international sponsor or in collaboration with domestic person(s) or firm(s). In either case, the sponsor will be required to comply with the rules of the PFRDA, the Companies Act, the regulations of the RBI, FIPB rules and other Government regulations.
8. A PFM will be required to maintain a minimum capital of Rs.25 crore. This capital requirement may be changed by the PFRDA in keeping with the AUM of the system and / or the structure for fines that may be applicable for PFMs.
9. A firm which has been indicted or de-licensed in any regulatory or legal proceedings by any domestic or overseas regulatory or legal body will not be eligible to bid for a PFM license.
10. **Other pre-conditions:**

a) The Sponsor(s) of a PFM shall at no time hold more than 10 per cent of the equity stake in any other PFM.

b) The Sponsor shall at no time hold more than 10 per cent of the equity stake in the CRA.

c) A PFM will be not be permitted to obtain custodial services from a custodian in which it holds more than five per cent equity stake.

d) No audit firm shall hold any equity stake in a PFM.

Report Card:LIFE

Life New Business Grows 50% in April

With the life insurance companies recording an overall healthy growth rate in the year 2003-04, insurers are expecting to build upon the gains of the previous year to maintain a steady growth rate during the current financial year as well.

A comparison of the data furnished by the insurers for the corresponding period in the previous year indicates a growth level of over 50% over April, 2003. The analysis also throws up the contrast in business underwritten during the months of April and March, 2004. The business underwritten by the life insurers in the month of April, 2004 is a mere 15% of what was underwritten in the previous month.

Premium underwritten by the private players in April, 2004 was Rs.15,518.93 lakh, viz., 17.67% of total premium underwritten. In comparison, LIC underwrote premium of Rs.72,304.62 lakh i.e., a market share of 82.33%. In terms of policies underwritten, the market share of the private players was 13.38% as against 86.62% of LIC.

The premium underwritten by the private players for individual policies stood at Rs.12,107.63 lakh, towards 89,918 policies with group premium accounting for Rs.3,411.30 lakh towards 84 schemes. The number of lives covered under group schemes was 1,01,392. Premium underwritten by LIC under individual schemes was Rs.41,983.25 lakh towards 5,81,855 policies, and under group schemes was Rs.30,321.37 lakh towards 588 schemes. The number of lives covered by LIC under group schemes was 2,64,535, i.e., 72.29% of the total lives covered.

ICICI Prudential continued to lead amongst the private players with premium at 6.15% and policies at 4.85%. In terms of number of lives covered, OM Kotak led with 21,325 lives viz., 5.83% of the total lives covered.

Premium underwritten by LIC under Varishtha Bima Yojana during the month of April, 2004 was Rs.26,734.25 lakh towards 13899 policies of which 29.60%, in terms of both premium and policies, was underwritten in the rural sector.

First Year Premium – April 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
1.	**Allianz Bajaj**	**1,378.97**	**1.57**	**6,073**	**0.90**	**458**	**0.13**
	Individual Single Premium	283.80		363			
	Individual Non-Single Premium	1,089.82		5,706			
	Group Single Premium						
	Group Non-Single Premium	5.35		4		458	
2.	**ING Vysya**	**221.32**	**0.25**	**5,587**	**0.83**	**0**	**0.00**
	Individual Single Premium	27.32		4,022			
	Individual Non-Single Premium	194.00		1,565			
	Group Single Premium						
	Group Non-Single Premium						
3.	**AMP Sanmar**	**230.25**	**0.26**	**2,215**	**0.33**	**1,045**	**0.29**
	Individual Single Premium						
	Individual Non-Single Premium	229.05		2,213			
	Group Single Premium						
	Group Non-Single Premium	1.20		2		1,045	
4.	**SBI Life**	**1,118.96**	**1.27**	**4,413**	**0.66**	**18,186**	**4.97**
	Individual Single Premium	371.69		150			
	Individual Non-Single Premium	228.52		4,260			
	Group Single Premium	408.25				4,963	
	Group Non-Single Premium	110.50		3		13,223	

(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
5.	**Tata AIG**	**1,751.72**	**1.99**	**16,752**	**2.49**	**19,318**	**5.28**
	Individual Single Premium						
	Individual Non-Single Premium	1,195.94		16,747			
	Group Single Premium	50.07				6,772	
	Group Non-Single Premium	505.72		5		12,546	
6.	**HDFC Standard**	**1,378.82**	**1.57**	**7,401**	**1.10**	**11,210**	**3.06**
	Individual Single Premium	540.88		779			
	Individual Non-Single Premium	766.60		6,600			
	Group Single Premium	71.33		22		11,210	
	Group Non-Single Premium						
7.	**ICICI Prudential**	**5,401.22**	**6.15**	**32,589**	**4.85**	**1,919**	**0.52**
	Individual Single Premium	859.93		693			
	Individual Non-Single Premium	3,492.72		31,882			
	Group Single Premium	1.07		1		214	
	Group Non-Single Premium	1,047.50		13		1,705	
8.	**Birla Sunlife**	**2,239.91**	**2.55**	**6,985**	**1.04**	**953**	**0.26**
	Individual Single Premium	86.40		1,775			
	Individual Non-Single Premium	1,413.61		5,208			
	Group Single Premium	31.90				268	
	Group Non-Single Premium	708.00		2		685	
9.	**Aviva**	**721.92**	**0.82**	**3,540**	**0.53**	**10,176**	**2.78**
	Individual Single Premium	30.96		28			
	Individual Non-Single Premium	671.05		3,507			
	Group Single Premium						
	Group Non-Single Premium	19.91		5		10,176	
10.	**OM Kotak Mahindra**	**507.03**	**0.58**	**1,253**	**0.19**	**21,325**	**5.83**
	Individual Single Premium	0.70		2			
	Individual Non-Single Premium	124.00		1,248			
	Group Single Premium						
	Group Non-Single Premium	382.32		3		21,325	
11.	**Max New York**	**394.20**	**0.45**	**2,506**	**0.37**	**4,655**	**1.27**
	Individual Single Premium	27.28		3			
	Individual Non-Single Premium	354.64		2,487			
	Group Single Premium						
	Group Non-Single Premium	12.29		16		4,655	
12.	**MetLife**	**1,74.61**	**0.20**	**688**	**0.10**	**12,147**	**3.32**
	Individual Single Premium	1.09		4			
	Individual Non-Single Premium	117.63		676			
	Group Single Premium						
	Group Non-Single Premium	55.89		8		12,147	
	Private Total	**15,518.93**	**17.67**	**90,002**	**13.38**	**1,01,392**	**27.71**
13.	**LIC**	**72,304.62**	**82.33**	**5,82,443**	**86.62**	**2,64,535**	**72.29**
	Individual Single Premium	3,919.25		8952			
	Individual Non-Single Premium	38,064.00		5,72,903			
	Group Single Premium	30,321.37		588		2,64,535	
	Group Non-Single Premium						
	Grand Total	**87,823.55**	**100.00**	**6,72,445**	**100.00**	**3,65,927**	**100.00**

Note : LIC figures exclude Varishtha Pension Bima Yojana Premium of Rs. 26,734.25 lakh

Risk Hedge or Funding?

- The Reinsurance Claims Recovery Question

Dr. Som Majumdar

" There is nothing either good or bad, but thinking makes it so."

-William Shakespeare in 'Hamlet'

Abstract

Reinsurance is off-balance sheet capital provided by the reinsurers to the primary insurers so as to help them increase their underwriting capacity. Capital adequacy indicates the degree of strength in claims paying ability. When the insurer becomes insolvent, the capital is often called upon from the reinsurers to fulfil their commitment as debt servicing obligations.

The following article refers to various scenarios of distribution of reinsurance recovery to the insurance creditors drawing upon the issues related to legal ramifications. In order to buttress the viewpoints, some court cases from the Australian context have been referred to. The discussion then follows through the concept of risk transfer and risk financing mechanism in the realm of reinsurance to differentiate between financial reinsurance and traditional reinsurance in order to assess the applicability of each process of mechanism.

A contextual reference has been made to an Australian insurance company, viz., HIH Insurance (in liquidation) to examine the after effects of various reinsurance arrangements made with different reinsurers that provided some food for thought when dealing with reinsurance.

Prelude

Insurance is an invisible trade. This is more so when the arena changes to the game of reinsurance or retrocession business. The *sine qua non* of insurance or reinsurance operation is to service the capital adequately and appropriately. If the adequacy of servicing relates to the probability of increasing shareholders' value, its appropriateness concerns claims paying ability for which the capital in question was deployed.

Capital is a scarce commodity and it comes at a cost. Because debt capital appearing in the balance sheet involves constraint and cost, primary insurers often tend to increase their net worth in an attempt to increase their underwriting capacity by taking recourse to 'off-balance sheet capital' provided by the reinsurers , and further down the track, by the retrocessionaires. Depending on the market condition at a given period of time, the reinsurance capacity is usually accessed either through the traditional market or through capital market solutions in forms of 'financial reinsurance.'

Contractual features of reinsurance

Due to increased levels of competition in the international trade and commerce, the transfer of capital from reinsurer to insurer is fraught with difficulties. The situation becomes more complex when the reinsurers are called upon to meet their commitment to supply capital as debt servicing obligations to those insurers who are in liquidation.

Although reinsurance is international in scope and character, it is surprising that there is hardly any specific statute or condition of law governing such contracts. Each agreement is unique and therefore governed by established market condition and practice. Possibly as a result of limited role of judicial process, there is a substantial degree of uncertainty on many key issues within the reinsurance industries. Therefore, when reinsurance contracts lead to dispute on conflict of laws, they are resolved:

Although reinsurance is international in scope and character, it is surprising that there is hardly any specific statute or condition of law governing such contracts.

- First, on the basis of express intentions of the parties,
- Then, on the implied intentions inferred from other statements of the parties and, should these criteria prove insufficient,
- By the law applicable at the place of performance of contract. Unless otherwise clearly stated on the body of the contract, the place of performance of the reinsurance contract appears to be the place where the indemnity is provided.

Reinsurance is a separate contract between two specific parties: Insurers and Reinsurers. The original assured who is the centre-play within the whole gamut of insurance, does not have any privity of contract either with reinsurer or with the retrocessionaire. These principles are set out in many court cases and rulings.

The only possible exceptions to the above principle arise when the subject matter of contract is conditioned with 'cut through clause' or ' statutory intervention' when dealing with the insolvent insurers. Therefore, in the event of a claim involving a single risk or a portfolio of risks, the *modus operandi* of the reinsurance recovery is often brought to judicial process of ultimate decision. The issue becomes more complex when the retrocessionaires are involved in the claim sharing process or when the claim in question comes to the liquidator.

Retrocession process

Retrocession seeks to provide protection to the Retroassured for its 'Exposure to Net Account.' This is measured on the basis of the general underwriting philosophy and the established underwriting practice. The typical reinsurance clause that represents this protection is known as "Net Retained Line Clause" which says:

"This Agreement shall protect only that portion of any insurance or reinsurance which the Reinsured, *acting in accordance with its established practices retains net for its own account....." etc* etc.

The most important issue is therefore to set out what the standard underwriting practice usually followed by the Reinsured for its day to day underwriting activities is.

The essence of Retrocession is to provide protection against Net Exposure. It is not only aimed at underwriting a risk. The typical clause to safeguard the Reinsured's position in this regard is characterised in a clause known as "What Constitutes a Single Risk", which states:

"The Reinsured shall be the sole judge as to what constitutes any one risk subject

to the definitions set out in the Reinsured's underwriting instructions or guidelines . . . . . etc etc."

It is important to note that "Risk" hereunder is to be understood as "Exposure" based on the above interpretation. Some Excess of Loss covers, rather than leaving the determination of the aggregating event to the general law - and thus potential dispute as to the correct basis of aggregation, empower the reinsured to determine the basis of any aggregation (*Brown v. GIO Insurance Ltd, Cox v. Bankside Members Agency Ltd, Axa* v. *Field* are the cases in point). Therefore, the excess of loss contracts on retrocession, more often than not, provide that:

The reassured's definition of each and every loss and/or event shall be final and binding on the reinsurers hereon.

The reassured shall be the sole judge as to what constitutes each and every loss and /or one event. (Axa v. Field)

These clauses on their face conferred upon the claimant's discretion as to how any aggregation should be fixed. The Court of Appeal held that the clauses had precisely that effect, and that it is a matter of commercial expediency that a problem as difficult as this should be determined by the reinsured alone and without the need for legal proceedings.

Issue of reinsurance in liquidation proceedings

The very essence of seeking reinsurance is to spread the risk and therefore, when loss arises, recovery from different sources is initiated and the monies net of expenses are distributed to the claimants. The process, though it sounds simple, takes a complicated twist when the insolvency process sets in. The connotation of key words becomes the burning issue.

The issue of 'risk transfer' is called upon to differentiate the contract from reinsurance arrangement to funding arrangement. The issue of 'domestic risk' and 'foreign risk' comes into play to determine the nature of precedence in distribution of claims money. The *parri passu* principles are challenged to define the concept of matching and pooling of recovery due.

It is often argued as to what the reinsurer's position would be if they are called upon to contribute their share of liability to the claim even if the insolvent insurers did not make any cash payment to insurance creditors.

The reinsurers' position in meeting its liability does not diminish in quantum and remains to exist in full even if the cedant pays very little or nothing to the original assured following insolvency. Besides, the reinsurers cannot argue that their liability to pay shall commence only after the actual sum is disbursed by the reassured in settlement of loss or liability to the original assured on the strength of 'ultimate net loss' clause that was in existence within the reinsurance agreement.

The essence of Retrocession is to provide protection against Net Exposure. It is not only aimed at underwriting a risk.

The English case in the House of Lords decision in 'Charter Reinsurance Company LTD v Fagun [1996] 1 All ER 406; [1996] 3 ALL ER 46, and the US case in the Supreme Court of United States in 'Allemania Fire Insurance Company of Pittsburgh v Fireman's Insurance Company of Baltimore 209 US 326 [1908] have addressed these issues quite clearly. The court rulings surmised that "*it is not necessary the Reinsured should first pay the loss before proceeding against the Reinsurer upon the contract of reinsurance, the liability of Reinsurer to pay accrues immediately upon the accruing of the liability to the Reassured where the calculation of the amount of payment is important but not the timing of that payment.*"

Principles of '*parri passu*'

Upon a company going into liquidation, it is the general observation that all the reinsurance monies of whatever character or class be first recovered, pooled and then distributed to all the creditors involved under contract of insurance paying pro rata. This concept is known as "general matching and pooling" approach. However, problem arises when a particular claimant files an appeal demanding "narrow pooling approach" and asks for distribution of reinsurance money to be confined to those claimants whose contracts are backed by specific reinsurance or retrocession arrangement.

A case in point was tested in the law suit filed in the Supreme Court of New South Wales Australia in "New Cap Reinsurance Company Limited (in Liquidation)v Faraday Underwriting Limited (formerly D P Mann Syndicate) and Gerling Global Reinsurance Company of Australia Pty Ltd".

Two specific issues were raised in this case, viz., (a) whether a particular contract could be identified that was protected by retrocession arrangement (such as specific facultative reisnurance), and (b) whether original contract of insurance included a statement to the effect that the contracts are to be protected by reinsurance, i.e. by applying 'cut through clause'. This argument may be further explained in the following imaginary cases as below.

Observation: Risk- D is subject to "Cut Through Clause"

Risk Type	Sum Insured	Loss Value	Specific R/I	R/I Recovery
Risk- A	$200,000	$ 10,000	under	
Risk- B	$100,000	$ 50,000	20% Quota Share	$18,000
Risk- C	$ 50,000	$ 30,000	reinsurance	
Risk- D	$150,000	$150,000	30% Facultative	$45,000
Risk- E (primary layer)	$100,000	$100,000	50% Facultative	$50,000
Risk- F (top layer)	$400,000 $1,000,000	$400,000 $740,000	10% Facultative	$40,000 $153,000

The following arguments may now be raised:-

a) Under risk-D, original policyholder can have direct access to the reinsurance recovery in precedence over others. This means the liquidator will have net fund of $108,000 i.e. ($153,000 less $45,000) available for distribution, or

b) Whether the reinsurance monies of whatever character or class should be recovered, pooled and distributed (in this case $153,000) to all holders of insurance claims irrespective of character or class whether reinsured or not and to distribute '*parri passu*', i.e. a 'broad pooling and matching approach,' or, whether it would be prudent that the Risk-D, Risk-E and Risk-F should have a priority over others because these contracts were backed by specific retrocession arrangements for which the original premium might have been loaded by extra cost of reinsurance. The argument in this case, if this were not done, there would be a perceived inequality that some policyholders had contracts backed by reinsurance and others did not, i.e. a case of 'narrow pooling approach.'

c) Another issue may arise, namely, if Risk-E becomes a foreign national, how would the liquidator distribute the fund recovered in terms of precedence, i.e. whether the domestic creditor would get priority over foreign creditors.

d) Finally, if the entire reinsurance arrangements were made in the name of 'financial reinsurance' with the objective of improving the cedant's balance sheet instead of emphasising the concept of 'transfer of risk', how would the liquidator look upon the reinsurance arrangements to facilitate the recovery proceedings from the reinsurers.

(a) Direct Access to Reinsurer

The first case scenario provides a case of direct access to the reinsurer and to bypass the liquidator in claiming the insurance settlement. The very essence of reinsurance is its informal approach based on sincerity, honesty, good faith and trust and above all, a gentleman's understanding. Due to the almost universal presence of an 'arbitration clause' within the reinsurance agreements, very few reinsurance disputes reach the courts and possibly therefore, there is a limited role of judicial process.

To what extent the reinsurance recoveries are feasible will depend upon how strongly the principles of 'insurable interest' are established. The direct insurers do not acquire and insurable interest as such in the property or liability they have insured. However, when they are prejudiced by a valid claim can they acquire a secondary insurable interest, which entitles them to seek reinsurance.

Likewise, there is no privity of contract between the original assured and the reinsurer. The contract of insurance and that of reinsurance are independent of each other and therefore, the original policyholder, in normal circumstances, cannot take actionable rights on the reinsurance contract, nor can he incur any liability thereunder. This principle of law has been established in the court case of "English Insurance Company v National Benefit Assurance Company (1929)".

The reinsurers' position in meeting its liability does not diminish in quantum even if the cedant pays very little or nothing to the original assured following insolvency.

The above situation is somewhat altered when the 'cut through clause' or 'loss assumption clause' is inserted within the original contract of insurance which is the subject matter of reinsurance. Although this is not very common, in the US market this is a common practice , but in the UK market, such alteration is generally made in the case of retrocession contracts. In such a scenario, the reinsurers agree to accept service of suit directly from such a direct insured or the financier.

With reference to Australia, its Corporations Law is very clear in this direction. Section 562A of the Corporations Act 2001 allows the policyholder to have a right of claiming the settlement proceedings to his claim directly from the reinsurer, thereby by-passing the insolvent insurer, and consequently the liquidator.

(b) Broad Pooling v Narrow Pooling Approach

The second case scenario from the above list of examples speaks of narrow pooling approach while applying the reinsurance recoveries. The priority of reinsurance payment in discharging claims was considered in the Supreme Court of New South Wales, Australia in the law suit of "Butterell v The Douglas Group Pty Limited [2000] NSWSC 492.

The main issue hereunder was whether the entire proceeds of reinsurance recovery are to be distributed '*parri passu* to all the insurance creditors, big or small, or the reinsurance monies should be confined only to those contracts that caused the recovery. The judgement in this case was passed in favour of the insurance creditors whose claims exceeded the excess point of the reinsurance treaty on a matching basis. The small claimants did not get the priority payment provisions. Thus, a narrow pooling approach was seen in operation.

(c) Foreign Reinsured v Domestic Insured - Who Gets Precedence?

In the above example, there is a clear conflict between two creditors, domestic and overseas in getting the priority of payment over the claims money. In the case law of 'New Cap Re Australia' as mentioned in the preceding paragraphs, Faraday Underwriting Limited (Formerly D P Mann Syndicate) was the foreign reinsured that posed a problem to the liquidator in determining whether liabilities outside Australia will rank below the Australian creditors of New Cap Re.

In this scenario, the interaction between 'State Statute' and the 'Federal Statute' was the matter of concern. The law says that in the event of a conflict between two laws for its application, the Federal Statute usually prevails. This is because the provisions of 'Corporations Law' for determining the precedence in the instant case were different from those of 'Insurance Act'. However, since the Insurance Act was Federal Statute in terms of efficiency and currency, it prevailed, and under its provisions, the foreign creditors were to rank behind the Australian creditors. Although there might be some arguments amongst different schools of thought, the general consensus is as above.

(d) Financial Reinsurance - A Case Study of HIH Insurance

Unlike traditional methods of reinsurance that give effects the transfer of risk, financial reinsurance is a different kettle of the fish, the essence of which lies in 'funding mechanism.' According to the Insurance Regulatory Authorities of Australia, "only those contractual arrangements that involve material transfer of insurance risk, particularly the underwriting risk, will be considered as reinsurance. A contract that may contain an element of insurance risk but which is essentially a financing or funding arrangement, should be accounted for as a loan."

Therefore, when the traditional reinsurance influences the operating results, the financial reinsurance aids in improving the balance sheet. To put it more simply, the reinsurance transactions aid in reducing the net claims position to boost profits and consequently avoid large fluctuations in earnings [and subsequent fluctuation in share price.]

By contrast, financial reinsurance though a valid transaction in the form of funding or loan arrangement that gives an improved look to the balance sheet position, accounting them as reinsurance transactions, can tell a different story. This is because transactions like this that lack transfer of risk, would normally allow the primary insurer's receipts to be classed as profits, masking what really were loans.

HIH Insurance, a giant insurance company in Australia experienced a financial collapse in March 2001with a reported deficiency of A$5.3 billion leading to the establishment of the Royal Commission to find out the actual reasons for the collapse.

While releasing the report, The Hon. Mr. Peter Costello MP, the Treasurer of Commonwealth of Australia in his Press release No. 020 dated April 20, 2003, said,"the Commissioner concluded that the primary reason for the collapse of HIH was the failure to provide properly for future claims. This failure was essentially due to mismanagement and inadequate response to pressures emerging insurance markets internationally."

On reference to various newspaper reports in Australia it is noted that HIH Insurance entered into different forms of contractual arrangements with many reinsurers including Hannover Re.

"The arrangements which involved HIH paying premium to Hannover Re as well as further payments to Treaty Services,

There is no privity of contract between the original assured and the reinsurer. The contract of insurance and that of reinsurance are independent of each other.

included letters of credit, a side-letter and trust deeds as well as reinsurance contracts ... despite being called reinsurance arrangements, there was no transfer of risk."

According to the report of the Sydney Morning Herald dated February 20, 2004, the New South Wales Supreme Court of Australia after a careful hearing, approved a deed that would cancel about 10 to 15 reinsurance and other types of financial arrangements. These arrangements were entered into by HIH Insurance whereby a reported refund of about A$300 million was made over to the HIH Liquidator.

Conclusion

The lesson that can be learnt from the above case histories is to understand how the transfer of risk is activated in adjusting the claims reserve. The *sine qua non* of reinsurance lies in the risk transfer mechanism, and more particularly, the underwriting risk that will make room for adjustment of operating profits and hence the share price of the listed stock.

In contrast, a funding mechanism simply involves transfer of assets from one account to other and does not affect the operating results of the company.

Financial reinsurance is largely considered as the means of risk financing. This is primarily used to access the capital market. However, if the element of reinsurance is to be inserted within its framework, the concept of 'Risk Transfer Securitisation' that gets activated through parametric trigger, may deserve special consideration. Therefore, the linguistic equipment that is used to draft the so called reinsurance arrangements need careful attention, should one want to ride the insurance horse dexterously.

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Court Fees for Consumer Courts

H. K. Awasthi

The days of subsidy and free service are over.

The Consumer Protection Act, 1986, was enacted to provide speedy, simple and inexpensive redressal of consumer disputes. With increasing awareness of consumer rights among the public as also the creation of solidarity among customers and consumer activism and education by voluntary organisations, there has been a tremendous increase in the consumer complaints filed before the consumer fora.

A three tier quasi judicial machinery i.e., one National Commission, 35 state commissions and 571 district forums has been set up in the country under the provisions of the Act. The consumer disputes redressal forums are required to dispose of cases as far as possible within 90 to150 days. These fora are available to consumers in addition to the civil courts and other legal forums. Till the quarter ending June 2003, the total number of cases filed and disposed of in the National Commission, state commissions and district fora are given below.

Many of the consumer fora have not been provided with adequate accommodation, infrastructural facility and staff. This is one of the factors affecting the proper functioning of the fora and their disposal of cases. Inadequate budgetary provisions, non-delegation of financial and administrative powers and delayed financial sanctions to meet the requirements of the state commissions/ district fora is another reason for delay in disposal of cases by the fora.

However the Department of Consumer Affairs launched a scheme of one-time financial assistance of Rs. 61.80 crore during 1995-99 to supplement the efforts of the states/ union territories for strengthening the infrastructure of the state commissions and district fora. Each state commission was given Rs. 50 lakh and each district forum Rs. 10 lakhs in four equal instalments, so that they were able to clear the backlog of pending cases.

> To discourage consumers from filing frivolous complaints, the Consumer Protection (Amendment) Act, 2002, has provided that complaints filed with a district forum shall be accompanied by the prescribed amount of fee.

Since the Consumer Protection Act, 1986, did not provide for payment of Court fees for filing a complaint before the fora, consumers have been filing complaints on flimsy grounds with inflated claims. At times on the day of hearing they have failed to appear to plead their cases. Thus the fora were burdened with complaints of consumers who were not serious in pursuing the matter.

Redressal Agency	Cases Filed	Cases Disposed	%
National Commission	30,799	22,958	74.5
State Commissions	2,72,396	1,77,269	65.1
District Fora	17,48,905	15,05,744	86.1
Total	**20,52,100**	**17,05,971**	**83.1**

Although Section 26 of the Act provided for the dismissal of frivolous or vexatious complaints and payment of costs

in Rupees

Compensation claimed	Court Fee
Upto 1 lakh	100
1 lakh and above but < 5 lakh	200
5 lakh and above but <10 lakh	400
10 lakh and above but not > 20 lakh	500

the fora did not take harsh actions and gave opportunity to the complainants to present their case.

Nevertheless in order to discourage consumers from filing frivolous complaints, the Consumer Protection (Amendment) Act, 2002, has now provided in Section 12 that each complaint filed with a district forum shall be accompanied by the prescribed amount of fee. Now in terms of rule 9A of Consumer Protection (Amendment) rules 2004, effective from March 5, 2004, court fees has been prescribed for filing any complaint with a district forum. (See table above)

The fee can be paid through crossed Demand Draft drawn on a nationalised bank or through a crossed Indian Postal Order drawn in favour of the Registrar of the State Commission and payable at the place where the State Commission is situated.

The rates of court fee for filing complaint and appeal before the state commissions and the National Commission are under consideration of the Government of India and are to be notified in due course.

Thus today the consumer cannot file complaint with the District Forum without paying court fee.

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Compensation Should Vary

H. K. Awasthi

In terms of section 14 (d) of the Consumer Protection Act,1986, the consumer forum can direct the opposite party to pay compensation to the consumer complainant for any loss or injury suffered by the consumer due to the negligence of the opposite party. Therefore if a consumer sustained any loss or damage actually, he is entitled to compensation.

The power and duty to award compensation by the consumer forum does not mean that compensation can be awarded in all matters at a uniform rate of 18 per cent per annum irrespective of facts of the case. The compensation has to be based on a finding of loss or injury. The forum or the commission must determine that there has been deficiency in service and / or misfeasance in public office which has resulted in loss or injury. Award of compensation shall vary from case to case depending on the facts of each case as the compensation cannot be uniform.

It has become a common practice to claim compensation @ 18 per cent p.a. for all losses, harassment or injury. The question whether a rate of interest @ 18 per cent is justifiable has been decided by the Hon'ble Supreme Court of India in the case of Ghaziabad Development Authority vs. Balbir Singh II (2004) CPJ 12 (SC).

While deciding a batch of matters the Apex Court examined the issue in detail in the background of precedents, laid down the criterion for granting 18 per cent p.a. interest as compensation which is awarded for harassment by public authority to the individual personally and also to help in curing a social evil. It may result in improving the work culture and help in changing the outlook. The Consumer Protection Act, 1986 has a wide reach and the commission has jurisdiction even in cases of service rendered by statutory and public authority.

The word compensation has a very wide connotation. It may constitute actual loss or expected loss and may extend to compensation for physical, mental or even emotional suffering, insult or injury or loss.

The provisions of the Consumer Protection Act enable a consumer to claim and empowers the commission to redress any injustice done. The commission or the forum is entitled to award not only the value of goods or services but also to compensate a consumer for injustice suffered by him. The commission/ forum must determine that such suffering is due to malafide or capricious or oppressive act. It can then determine the amount for which the authority is liable to compensate the consumer and direct the authority to pay compensation and, then, also direct recovery from those found responsible for such unpardonable behavior.

The compensation has to be based on a finding of loss or injury. It cannot be uniform as no hard and fast rule can be laid down.

No damages are payable for mental agony in cases of breach of ordinary commercial contracts. The forum or the commission must determine that there has been deficiency in service and /or misfeasance in public office which has resulted in loss or injury. Compensation cannot be uniform as no hard and fast rule can be laid down. The Apex Court cited the following examples where the compensation cannot be uniform.

i) Where possession is being directed to be delivered the compensation for harassment will necessarily have to be less because in a way that party is being compensated by increase in the value of the property he is getting.

ii) Where monies are being simply returned then the party is suffering a loss in as much as he had deposited the money in the hope of getting a flat / plot. He is being deprived of that flat / plot. He has been deprived of the benefit of escalation of the price of that flat / plot. The compensation in such cases would necessarily have to be higher.

iii) If the construction is not of good quality or not complete the compensation would be the cost of putting it in good shape or completing it along with some compensation for harassment.

iv) If at the time of giving possession a higher price or other amount is collected unjustifiably and without there being any provision for the same the direction would be to refund it with a reasonable rate of interest.

v) If possession is refused or not given because the consumer has refused to pay the amount, then on the finding that the demand was unjustified the consumer can be compensated for harassment and a direction to deliver possession can be given.

vi) If a party who had paid the amount is told by the authority that they are not in a position to ascertain whether he has paid the amount and the party is made to run from pillar to post in order to show that he has paid the amount, there would be deficiency of service for which compensation for harassment must be awarded.

vii) If after delivery of possession the sale deeds or title deeds are not executed without any justifiable reason, the compensation would depend on the amount of harassment suffered.

These examples are not exhaustive. Awarding interest at a flat rate of 18 per cent per annum irrespective of the facts of each case is unsustainable. Award of compensation shall vary from case to case depending on the facts of each case.

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Going to the Customer

K. Nitya Kalyani

New initiatives always bring new puzzles to solve. So it is with alternate channels of distribution. Technology lends a hand, and challenges you with more questions as it answers old ones.

Alternate channels of distribution of insurance can broadly be classed into two. Those that open up due to availability of technology and those that are devised to reach markets not exploited too well until now.

The former are more relevant to urban markets and include the Internet, call centres, telemarketing and direct mailing (the technology here lurking in that most potent business asset – the customer database.)

The latter are localised service institutions that know and work with rural and socially weaker communities. They spread literacy, support livelihood creating programmes and foster the need for sustainable development and financial security among them. They are opinion leaders in these hard to reach, and as yet hardly reached, communities and have worked successfully with micro finance programmes. Insurance is one more dimension for them and the experience of the two sectors coming together has been heartening though shaky from both sides.

The market for insurance is not homogenous. Considering that spreading of risk is the basic tenet on which the business logic of insurance is founded, it is apparent that the market for insurance *should not* be homogenous for the product and its benefit to be stable. Hence the need to reach out to more and more niche markets through means that are best suited to reap the best harvests in those areas.

The tied agency system – that LIC, the erstwhile GIC companies and many of the private sector companies also follow largely – is still by far the largest channel of distribution of insurance products. Corporate agencies, including bancassurance holds great promise and is slowly coming into its own with a few outstanding examples. Broking too is going through its initial teething troubles and anyway has been the proven marketing model only for higher end non-life policies though there are interesting new patterns being created in life (essentially retail) insurance marketing by brokers.

While nothing beats the human touch in selling insurance, it is interesting to have a look at what the industry is trying to do with newer methods of reaching out to their markets.

They are not getting in much business yet, but new marketing methods (new to insurance, that is,) like direct mailing or using the Internet certainly occupy significant mindshare among the top management. Let us see how companies choose their channels and some experiences in the market.

> New marketing methods occupy significant mindshare among the top management.

Take the case of Royal Sundaram Alliance Insurance Ltd. (RSA). It has a direct mailing initiative as part of the work that its corporate agent, Standard Chartered Grindlays carries out.

Choosing the product that would match the bank's customer base is the first step, says Mr. Antony Jacob, Managing Director of RSA. "If necessary a new product is made and then the bank sends the specially created marketing literature to customers with that profile."

RSA has met with success rates of eight to 10 per cent where two per cent is seen internationally as a good strike rate. The targeting of customers and suitable packaging of the product used some of the learnings of RSA in Asia, he says. For example, there is not much first mover advantage in an insurance product – another company can release a clone in a matter of weeks. That is where, he says, excellent literature and offer letters – the special packaging – make a difference.

Telemarketing, on the other hand, is a different ballgame. RSA's approach to telemarketing has seen that a customer of a foreign bank is a better target than that of a typical nationalised bank. "Because he has become accustomed to dealing with it this way," he explains. The strike rate here is again about one to eight per cent, with personal accident policies seeing a three to four per cent sales rate. About five per cent of RSA's personal lines business is generated through telemarketing, a new channel for the company, which is already finding it a costlier channel!

Is it not being seen more as a disturbance? "It's an absolute nuisance," he admits personally, specially if they call during working hours. He takes the calls though, to evaluate what the others are doing!

Commenting on the inevitable data privacy standards that will be set up, he says that it would probably help improve their strike rates. When a customer has allowed himself to be contacted for marketing purposes then the marketing is likely to be more focused. "I would rather target 100 customers who have opted in rather than 200 who have said nothing. Even if I get the same number of sales from both, the former is more cost effective for me."

And as for the Internet, RSA has not tried it yet. "We don't feel the market is mature enough yet for completion of sale,' he says.

On the rural side RSA has found that micro finance institutions constitute a

growing set of lenders seeking protection for their borrowers under group policies. "They are getting pretty good spreads, and are doing a wonderful job!"

Basix, an Andhra Pradesh based NGO, which has been in operation for eight years has as its mission of promoting livelihood in rural areas. This started with credit to the rural poor for engaging in economic activities and earning an income. It then moved to insurance for protecting their financial status and livelihood.

"We also see it as a good avenue for long term savings services," says Mr. Devarakonda Sattaiah, Associate Vice President, Basix, who is also the corporate insurance executive in charge of the NGO's relationship with Aviva Life Insurance Company.

Insurance selling is a new activity for Basix which works in five states and 28 locations. It has 280 customer service agents who are graduates from the local villages looking after 10 to 12 villages each.

Basix works in business development services providing input-output linkages, capacity building, farming practices improvements, market linkages and the like for local farmers for cotton and vegetable farming and sericulture. Its institutional development service uses the inputs it gets from organisations to help rural organisations develop. It already has a very strong management information system providing capacity building for 26 organisations for sectoral development.

From buying a master policy to cover its own credit customers with group insurance products from Aviva, Basix now is on a pilot programme to sell individual policies even to non-credit customers. From January this year the programme has been running in 12 locations.

"We expect to sell eight to nine policies per CSA per month," says Mr. Sattiah and Basix executives are undergoing IRDA stipulated training. It is the executives who do the selling while the CSAs doing the follow up work on a weekly basis.

The aim is to make the CSA the selling point, and for this he says that the IRDA restriction on having sub-agents is a constraint. The reason? With CSAs he can instantly reward good performance and penalise poor output without getting into the employment trap that rural and cooperative banks have got into that entail higher cost commitments but don't ensure productivity. Permission to appoint sub-agents could be given on a case to case basis on the corporate agent proving their bonafides, he suggests.

The initial reluctance to buy insurance is overcome because the customer knows the reputation of Basix, he says. The identity of the insurance company is irrelevant!

Some interesting insights emerge in a chat with Mr. Sattiah. The initial reluctance to buy insurance is overcome because the customer knows the reputation of Basix, he says. The identity of the insurance company is irrelevant!

This is because of the goodwill and reputation that the NGO has built up on the ground through working for their livelihood concerns. It knows the customers, their cashflows and financial requirements closely, and has built up their trust enough for them to feel at home taking their advice on financial matters.

"They have been seeing us for seven to eight years," Mr Sattiah puts it simply. "They know our efficiency and helpfulness."

The going is slow though and that his a characteristic of the market. The average sum assured is about Rs. 23,000 and the premium Rs. 220. Basix offers one term product and one premium return product now and is beginning to sell livestock and other non-life products as well.

Under the group policies it had 53,000 customers last year. Of their Rs.50 crore worth loans Rs.40 crore was eligible for coverage. Coverage can be up to 150 per cent of the loan amount and so Rs. 60 crore sum assured was generated with premiums around Rs. 8.6 lakhs. Basix does not earn through this activity being the master policy holder but the insurance company has been enabling their entry into selling by providing training subsidy and the like.

The IT enabled NGO reports its claims by e-mail and of the 72 claims reported last year, 53 have been settled.

Constraints he faces are unique to the rural setting. The main challenge in claims settlement is being able to furnish the specific reason for death. Deaths are not reported or registered and the rural medical infrastructure does not support this kind of documentation and on cannot expect a villager to entertain a police visit for the purpose, he points out.

We are trying to educate the insurance companies that they have to take into account rural realities. They should be able to see that moral hazard (suicide) would be slight for such small policies.

Other problems are age proof and the NGOs own transaction costs, specially given the small amounts of premia and perhaps the refunds.

And hence another suggestion: transaction costs would be contained if our units can send us advice and we make payments to the company – something that agents are not allowed to do now. Maintaining multiple accounts (in five states and 28 locations – all small towns –) for remitting premiums according to the regulations increases work and transaction costs.

Basix also works on creating alternate channels for insurance companies. Fertiliser dealers, for instance. This comes as part of its strategy for mission achievement which is to distribute all insurance products which will have a positive impact on members' livelihood. They prefer to work with companies that work with small groups and can learn from that and develop products.

A major constraint is that the insurance companies don't put in an equal amount of energy to understand the business needs of rural customers – they just want to meet regulatory requirements!

The Internet, at the height of the dotcom boom, was expected to become a dominant marketing and distribution channel for intangible products. But so far it has not transformed into much more than a lead generation method. Simpler insurance products like travel and personal accident insurance, and perhaps some motor insurance has been written on the net in other markets.

There have been some initial, interesting successes like Birla Sunlife selling life insurance policies from their website and of Tata AIG selling marine cargo policies through their e-marine programme.

Direct marketing can happen in many ways. Ask ICICI Prudential Life Insurance Company. It sent 50,000 direct mailers to office-goers in Mumbai through a hard to miss mode - their lunch boxes! In February this year, tax season, the targets received a mailer with the visual of a bitten apple warning them that the taxman was going to take a bite out, and to buy retirement solutions to prevent it!

"It had a huge impact," says Mr. Abhishek Bhatia, Head, Marketing ICICI Prudential, who declines to put a number to it. The conversion rate was 70 to 80 per cent higher than their other direct mailing efforts where a one to six per cent is considered good depending on the category of product and its pricing.

The Internet, at the height of the dotcom boom, was expected to become a dominant marketing and distribution channel for intangible products.

About three per cent of the company's premiums come from channels that don't include agency or bancassurance he says. And the company is already conscious about overstepping the limits in its database marketing activities.

"We are careful and contact people only on a permission basis," he says. They contract only opt-in databases and, on the Net, follow all the US anti-spamming practices since India does not have these laws.

Another precaution is to keep records of how many times a customer is contacted, to avoid customer irritation. While the databases and the Internet are used only for lead generation, telemarketing – though its call centres – are for follow up. This is how it has been working abroad, he says, and that is how it is shaping up here as well.

The life insurance broker is a unique animal in the Indian market. Following from selling personal finance products mutual fund, IPO and corporate fixed deposit brokerages like Bajaj Capital or Anand Rathi have now turned their attention to life insurance products as well. They choose a few life companies who provide the width of products they require to offer a full menu to customers and Tata AIG Life Insurance Company for one, has found it a successful channel. "We believe in broking, we are investing in it, we keep training them and holding customer meets to help them," says Mr. Joydeep Roy, Director, Alternate Channels of the company.

The channel, according to him, offers value to the customer, and it is time that life brokers get a freer commission structure.

On the rural side, his company sells through NGOs in remote areas, and using the grant it received from Britain's Department for International Development (DFID), under its Financial Deepening Challenge Fund (FDCF), has been developing a successful rural selling model, equipping NGOs with training and infrastructure.

The company has been doing well on that front as a result, and has collected Rs. 7.5 crore as premiums from rural areas for individual coverage.

Its community rural insurance group (CRIG) is carved out of a self help group (SHG). Tata AIG Life helps the CRIG form a company and acquire a corporate agency selling insurance to SHG members and to the richer farmers. The system has been working well for three quarters now and Mr. Roy is eagerly awaiting the outcome of the third quarter audit.

The Road Less Travelled

V. Krishnan

"It is the happening time now - in the Indian insurance industry, and how I wish I was 30 years younger" – so sighed a senior insurance execute at a recent conference, thus capturing the spirit of dynamic changes and challenges that are taking place in the market today.

Expanding Reach is the mantra today of all Insurers and particularly the private sector companies. Achieving this quickly, efficiently and cost effectively is the fuel that propels alternate distribution channels. Basically, any vehicle of distribution, other than traditional primary channels (agency and brokerage) can be termed as alternate channels. Noted insurance consultant Barry Robkin clearly predicted, "the winds of change are blowing."

This change is being largely driven by carriers / distributors, who want to maximise their earnings tapping insurance potential of their client contact base, capitalise on communication technologies, changing lifestyles and an increasingly growing segment of younger age buyers, who are very comfortable with technology.

Value Propositions

Analysing the effectiveness of alternate channels is quite complex because there are both success and not so successful stories around the world. Also there have been ups and downs, which may be due to a host of factors – from regulatory to holding on to the basic customer relationship as a primary carrier.

However, what is very clear is that for life insurance companies where the cost of acquisition is very high through traditional channels – as high as 45 per cent – using alternate distribution channels is a good value proposition to invest in and explore, as it can clearly bring about cost reduction. For non-life insurers, particularly in India, where the cost of acquisition does not exceed 15 per cent (due to regulations), the value proposition offered by alternate distribution channels becomes increasingly less luring, unless they find ways and means to go beyond the 'Lakshman rekha.'

They either hit critical mass volumes or have a cost plus arrangement or even work a profit share with the insurers. Basically what works on the Life side may not necessarily work in the nascent stage in the Non-life side unless clear enablers are put in place – both in terms of licencing and cap on acquisition costs

The insurance environment in India

To quote Mr. T. K. Banerjee, Member (Life), Insurance Regulatory and Development Authority (IRDA), life insurance premiums rose to Rs 18,710 crore (Rs 187.10 billion) in fiscal 2004 from Rs 12,300 crore (Rs 123 billion) in 2002-03. The massive growth comes chiefly on the back of sale of unit-linked plans, group policies and pension plans. The Life insurance market showed a decline of 18.5 per cent in fiscal 2003 from Rs 15,100 crore (Rs 151 billion) in 2001-2002 following a slowdown in sales of single premium policies. This was even as the private insurance players witnessed combined growth rates of over 330 per cent.

For life insurance companies where the cost of acquisition is very high through traditional channels using alternate distribution channels is a good value proposition.

The Indian insurance sector has witnessed new premium income of Rs 34,828 crore (Rs 348.28 billion) in fiscal 2004. This reflects a growth rate of 33 per cent over fiscal 2003's aggregate figure of Rs 26,203.8 crore (Rs 262.03 billion).

Against a growth rate of 51 per cent for life insurance business, non-life insurance premiums rose by 16 per cent to Rs 16,118 crore (Rs 161.18 billion) in fiscal 2004.

The Non-life insurance sector accounted for a higher share of the aggregate new premium income with Rs. 13,879 crore (Rs 138.79 billion). However, in fiscal 2004, Life insurance business accounted for over 53 per cent of the total new business.

We are indeed in exciting times and these phenomenal growth rates are mainly due to 'expanding reach' and 'cross sell' initiatives through a variety of distribution channels.

Alternate distribution channels in the marketplace

The distribution revolution has picked up momentum for various providers – meaning that insurance is being sold in various forms – from medical stores, departmental stores, garages, petrol stations and banks. Let us have a bird's eye view of the various opportunities in the market.

1) Direct Marketing – In this case the insurer launches a plain vanilla product, which is easy to understand, creates immediate interest and encourages the customer to call a toll free number. Telecallers do the rest, and thus through secured credit card payments gateway – premiums are received and the policy subsequently delivered to the customers.

2) Call Centres – Various models are being experimented with. Insurers have in-house call centres, which makes out bound calls on "a known target segment database" or alternatively the whole initiative is outsourced to a call centre which is provided with enough data through affinity partners – e.g. database of mobile users may be made available (by mobile phone companies and insurers on a win-win understanding) for selling simple Life and Non-life policies.

3) Automobile manufacturer tie ups – Here again is a very unique way in which Non-life insurers have tied up with automobile manufacturers and ensured that their authorised car dealers provide "free insurance" (actually free for the insured, but first year premium paid by the sponsor, who is the car dealer – who in some way is 'compensated' by the manufacturer) for all new cars sold in the market. Maruti and Hyundai are clearly two best cases, and they account for nearly 75 per cent of new car sales.

4) Forex dealers / large travel related relationship services – Here again we see large organisations who have wide distribution networks like LKP Forex, Thomas Cook, Western Union and also those involved in visa processing for consulates , chains of tourist hotels / car rental services tying up with insurers / distributors of travel related policies to canvass and sell particularly overseas travel insurance policies .

5) Worksite marketing – This is again an excellent route by which insurance companies create in-house worksite marketing teams, who are very skilled and experienced in selling value propositions to individual employees of a large organisation on one-one individual meetings. The policies are so structured that there is no feeling of 'pinching of the wallet,' as it involves deduction of small regular monthly premiums from the payroll. Once the customer is in the programme, there is little anxiety that he may firmly choose to opt out later. The costs are initially high but get amortized over the years.

6) Internet based – This is enabled by the fact that there is a target segment that is comfortable with the use of the Net. The last year has also seen insurers selling simple products like Motor insurance, home insurance and Personal Accident insurance over the Net.

7) Departmental stores / affinity groups / retailers of white goods – Here again a beginning has also been made with insurers tying up with large departmental chains – like Shopper's Stop or Westside, to tap customers through a bundled offer or offer across the counter choice to close the case.

8) Marine cargo insurance through clearing and forwarding (C & F) agents / transporters / courier companies – A definite move is on to tap these service providers – by providing them with technology support which enables them to issue marine policies anywhere and anytime. An excellent example is the ATM (Anytime Marine) proposition through e-marine by Tata-AIG.

Benefits of e-marine:

- The client can issue Marine insurance certificates any time, anywhere – from the comfort of his office/home to meet his business requirements.
- Any number of users in the client's organisation even from different locations can operate e-marine with distinct user Ids and passwords.
- The certificates can be viewed at various stages during issuance. Changes, if any, can be made then and there ensuring quality documentation.
- As the records get updated simultaneously at our office too, there is no need to submit separate declarations/details of certificates issued.
- Balance available in the deposit a/c can be viewed by the client at any point of time facilitating timely replenishments.
- The unique encryption code on every insurance certificate facilitates verification of its authenticity by any third party, anywhere in the world by simply logging on to our website and giving the code details.
- Absolutely free! Being an added benefit we offer our clients, there is no fee charged for e-marine usage. Neither is there any need to install additional software .The only requirements are Internet connectivity and Acrobat Reader Version 4 and above.

> The critical factor for alternate distribution channels to be successful is technology.

9) NGOs / Village Panchayats – Particularly in the field of rural insurance, the last mile contact is achieved at a much lower cost – through successful strategic tie-up of large insurers with a host of NGOs.

10) Chit Funds / Transport finance companies – An example to quote is of AMP Sanmar, which has successfully tied up with various chit funds and transport finance companies in the country, through whom it is selling life policies – riding on the back of fixed deposits and bonds.

11) Global Relationships - Insurers have capitalised on such relationships, examples being GE, Kotak, Tata AIG Life), Swiss Life International (OM Kotak).

12) Bancassurance – This works out exceedingly well for life insurers than in the case of non-life insurers. There area host of challenges – whether the bank only provides the lead or the bank actually prospects , informs and then closes the deal with their customer. SBI Life , AVIVA , ICICI Prudential, & Tata AIG Life have clearly made inroads. In the case of Non life – in view of a large product range underwriting criteria, there continues to be a challenge .

"Our bancassurance channel – with tie-ups with four banks – contributes almost 70 per cent of our total sales," says Aviva CEO Mr. Stuart Purdy.

OM Kotak Mahindra Life, which is ranked eighth among private players, is also leaning towards alternative distribution channels that will contribute to 45 per cent of total sales, in line with the contribution from its tied agency force.

The critical factor for alternate distribution channels to be successful is technology.

- An application that can be filled out on the computer and a questionnaire with drill-down questions to get additional details where merited
- Expert underwriting technology
- Automatic retrieval of supplementary data and other underwriting data
- Policy-printing capability.

If variety is the spice of life, then the insurance industry is indeed a spicy one. No one is forecasting that the traditional agent will disappear from the insurance landscape. In fact, agent / broker-generated sales of insurance products are predicted to grow at a much faster pace over the next five years, especially within the high net worth market. But distribution alternatives are here to stay, too. What we are yet to witness and feel is the array of new distributors that will enter the arena.

Indian Insurance distribution is truly shining and nothing can stop an idea whose time has come.

The author is Vice President, National Branch and Agency Operations, Tata AIG General Insurance Company Ltd. The views expressed here are his own.

New Channels, New Challenges

Rashmi Abichandani

Marketing of insurance products is assuming more and more importance and so are alternate channels for marketing. In urban areas this may include the Internet, automated teller machines (ATMs), call centres, direct mailing and so on. In the rural areas we are looking at microfinance institutions and NGOs. All these channels basically involve database marketing, this database being built by financial institutions/ companies or other service organisations by collecting information from their customers generally for their own use. For example banks collect information about their customers.

Developments in technology have also begun posing serious challenges to the seemingly inalienable value of individual privacy, particularly the privacy of their personal information. Advances in computer technology and in data collection techniques have allowed public and private organisations to collect vast quantities of information on consumers, including who they are, where they live, how much they earn and how they spend their money.

This information (customer database) is often either shared among affiliates of such companies or even sold to/ shared with other companies. Increase in scientific and technological co-operation has also led to cross-border flow of data.

The question thus is whether such sharing of information without prior consent/ information of the customer would infringe on a person's right to privacy?

For ages, privacy has been considered a human value worthy of protection. Privacy law has evolved largely through judicial pronouncement. Despite the lack of specific constitutional recognition the right to privacy has long held a place in international documents on human rights, such as Article 12 of the Universal Declaration of Human Rights, 1948, Article 17 of the International Covenant on Civil and Political Rights, 1966 (to which India is a signatory) and also Article 8 of the European Convention on Human Rights.

Unlike jurisdictions in several other parts of the world, the Constitution of India does not expressly recognise the right to privacy as a fundamental right. Nevertheless, in 1964 the Supreme Court recognised the right to privacy as implicit in the Constitution, under Article 21. This states, "No person shall be deprived of his life or personal liberty, except according to procedure established by law."

The first few cases that presented the Indian Supreme Court with the opportunity to develop the law on privacy were cases of police surveillance. The Court examined the constitutional validity of legislations that empowered the police to keep a secret watch on the movements of an individual, the first of these cases, being Kharak Singh v. State of U.P.

> Developments in technology have also begun posing serious challenges to the seemingly inalienable value of individual privacy.

In Gobind v. State of M.P., another case of surveillance, the Supreme Court appears to have acknowledged a limited right to privacy. Yet, the Court went further than the Kharak Singh judgement and upheld the impugned regulation, which authorised domiciliary visits in its entirety. This was on the ground that the object of the provision was the prevention of crime.

R. Rajagopal v. State of Tamil Nadu was a turning point in the development of the Indian law on privacy. For the first time, the Supreme Court discussed the right to privacy in the context of the freedom of the Press.

The case concerned the right of the publisher of a magazine to publish the autobiography of a condemned prisoner, "Auto Shankar." The respondents contended that the intended publication (which was to expose some sensational links between the police authorities and the criminal) was likely to be defamatory and therefore required to be restrained. The issue of the right to privacy came up in this context. The Supreme Court held that the Press had the right to publish what they claimed was the biography of Auto Shankar insofar as it appeared from the public records, even without his consent or authorisation. However, if the press items went beyond the public record and published his life story that might amount to an invasion of his right to privacy.

Similarly, the government and prison officials, who sought to protect themselves against possible defamation (by ostensibly seeking to protect the privacy of the incarcerated prisoner), did not have the right to impose a prior restraint on the publication of the autobiography; their remedy, if at all, could arise only after the publication.

Recently, privacy-related issues have cropped up in a variety of cases, ranging from biographical films to telephone tapping to the right of confidentiality of an HIV-infected person.

We may say that privacy broadly includes the following:

Bodily Privacy: This concern the protection of people's physical selves against invasive procedures such as genetic tests, drug testing and cavity searches.

Privacy of Communications and Information: This covers the security and privacy of mail, telephones, e-mail and other forms of communication. In relation to Information it involves establishment of rules governing the collection and handling of personal data, such as credit information, medical records and government records. It is also known as "Data Protection." And last but not the least:

Territorial Privacy: This concerns the setting of limits on intrusion into the domestic and other environments such as the workplace or public space, which includes searches, video surveillance and identity (ID) checks.

The European Union (EU) has come out with directives on protection of individuals with regard to processing of personal data and on the free movement of such data. This directive disallows flow of data to countries which do not have laws on privacy. Further these directives allows the Member states of the EU to specify the conditions under which the customer information would be shared with third parties subject to provisions allowing the individual whose data is being dealt with– the data subject – not only to know about the provision of data processing but also to object to such processing of data regarding him and at no cost and without having to state any reasons.

Similarly in Hong Kong there is an Ordinance regarding Privacy of Information. The principles enunciated therein provide for the use of personal data and clearly states that unless the data subject gives consent personal data should be used for the purposes for which they were collected or a directly related purpose.

In the US though the confidentiality standards for business dealing are matters to be dealt with by State Laws, the Fair Credit Reporting Act, (FCRA) and Gramm-Breach-Bliley Act (GBBA) have meant that the federal law generally controls consumer credit information and governs the disclosure and safeguarding of non-public personal information held by various financial institutions. The GBBA generally prohibits sharing of customer information unless the data subject is given an opportunity to opt out, however it does not prohibit sharing of information amongst affiliates. The FCRA amongst other things has provision allowing sharing of a wide range of data among affiliates but the customer should have an option of 'opting out' of such sharing and the states may make laws overriding this provision after January 1, 2004.

Thus under the amended GBBA, state insurance regulators were allowed to adopt standards more strict than the federal minimums provided in the law. This is unusual, because normally federal law in U.S would pre-empt stricter state action. However, insurers pressed the NAIC to encourage states to adopt uniform standards not very much stricter than those under the federal law. In the event, most states went along with what the insurers wanted, but with tighter protections for health insurance information.

For other insurance information insurance customers may 'opt out' of allowing financial information to be shared with non-affiliates, but they must notify the company that they do not want it shared. If they take no action, the information may be shared. While there are annual notices about the right to opt out, most customers ignore the legal jargon, so few do actually opt out.

Many have advocated an opt-in system, where the customer's privacy is protected unless he/she affirmatively agrees to allow it to be shared. Companies oppose this as too expensive and it is not the law in most areas. In fact, to ensure greater protection of the individual's rights, it would be better if, in addition to an 'opt in' system, he is told what the information could be used for. But companies usually resist such measures citing cost as a factor.

There is no general data protection law in India. However there has been a change in the outlook by the apex bank of India.

Since 1999 privacy requirements for health information have been set by US federal regulations under HIPAA (Health Insurance Portability and Accountability Act) that use 'opt in' and have significant consumer disclosure requirements for doctors and other medical practitioners.

There is no general data protection law in India. However there has been a change in the outlook by the apex bank of India. As we may remember the RBI had under its Know Your Customer (KYC) procedures required the banks to collect information from its customers with an intention to prevent money laundering.

Recently they have come out with instructions on customer information. This circular says that while the information collected from the customer is being used for cross selling of services of various products by banks, their subsidiaries and affiliates, sometimes, such information is also provided to other agencies. It goes on to point out to banks that the information provided by the customer for KYC compliance while opening an account is confidential and divulging any details thereof for cross selling or any other purpose would be in breach of customer confidentiality obligations. Banks have been advised to instruct all the branches to strictly ensure compliance with their obligations to the customer in this regard.

Further it has been stipulated that wherever banks desire to collect any information about the customer for a purpose other than KYC requirements, it should not form part of the account opening form. Such information may be collected separately, purely on a voluntary basis, after explaining the objectives to the customer and taking his express approval for the specific uses to which such information could be put. This is a wise and cautious move by the RBI reflecting contemporary concerns about financial data privacy and even potential identity theft.

This issue of sharing of customer information has been raised throughout the world and varied approaches are being adopted in the international arena. Even in the Indian context the question remains whether such free sharing of customer information without consent of the data subject or without giving him an option to opt out of sharing will or will not constitute infringing his right to privacy.

In this backdrop it is also essential to examine the consequences of a data privacy law if promulgated, on the new channels of business being adopted by companies including insurers and to prepare ourselves for the new challenges that may be faced in times to come.

A typical situation like this can be handled by the insurance companies either by conducting surveys by themselves and preparing their own database. Another option is that the institution/organisation while collecting such information from the public declares its privacy policy to the customer and explains to him that such information may be used for marketing other products like insurance thus making it voluntary on the part of the data subject to either opt in or not into such sharing as has been declared by RBI in case of banks.

Let us look at other issues arising out of using new delivery channels and some legal positions on them.

There has been an increase in e-commerce over the world and India is not too far behind. E-commerce is being accepted as a mode of business and is being also looked upon by insurers to be used as an alternate channel of business.

In May 2000, the Government of India passed its first cyber law, the Information Technology Act; a set of laws, intended to provide a comprehensive regulatory environment for electronic commerce.

The IT Act amongst other things provides for the following:

- It recognises email as a valid form of communication in India. Also, acceptance in an electronic form of any offer, culminating in an electronic contract, has also been declared legal and enforceable.
- The Act has recognised digital signatures for the first time in Indian Law.
- The said new law has also granted a hierarchy of infrastructure, consisting of a Controller for certifying authorities, Adjudicating Officers and Cyber Appellate tribunal.

Insurance, like other contracts, has to fulfill the requirement mentioned in the Indian Contract Act, 1872 and in addition has certain additional elements like the principle of insurable interest (defined in the Marine Insurance Act, 1963), and the principle of utmost good faith, though these terms have not been specifically defined in the Insurance Act, 1938. The insurance contract also needs a proper offer and acceptance.

The IRDA (Protection of Interests of the Policyholders's Interest) Regulations, 2002 mandate for a written proposal except in case of marine policies. This proposal forms the basis of the contract of insurance and is of immense importance more so since it contains a declaration from the proposer that the statements and information given by him are true and correct.

With the passing of the IT Act and due to the recognition it imparts to electronic documents and digital signatures is there not a possibility of insurers using this new e-commerce method to issue online policies?

Such positive use of e-technology by the insurance industry is going to give it a greater impetus and help in easier, faster and convenient marketing.

It is also worth mentioning that the Indian Evidence Act has also been amended to include provisions regarding admissibility of electronic records.

The newly incorporated Section 65B (1) of the Act provides that ' notwithstanding anything contained in this Act, any information contained in an electronic record which is printed on a paper, stored, recorded or copied in optical or magnetic media produced by a computer (hereinafter referred to as the computer output) shall be deemed to be also a document, if the conditions mentioned in this section are satisfied in relation to the information and computer in question and shall be admissible in any proceedings, without further proof or production of the original, as evidence of any contents of the original or of any fact stated therein or which direct evidence would be admissible. Subsection (2) gives the necessary conditions referred hereinabove.

Thus the earlier difficulty regarding enforceability and proof has also been overcome with the coming into force of this and other related sections.

Such electronic issuance of policies to the insured who agree to receive such policies electronically, cannot be ruled out as long as the insurance policies delivered to the consenting insured meets the requirements contained in the Insurance Act, 1938 and the regulations framed by the IRDA and is not in violation of the laws.

Furthermore, no matter what form the policy exists in, paper or electronic, the policy form, format and language that has been filed by the insurer with the regulator under the 'file and use' procedure must be adhered to.

An example of such electronic issuance of policies is the State of New York, where such electronic issuance of policies is allowed since the same is not prohibited under the insurance law and regulations applicable there.

Every insurance company in India that chooses to incorporate an electronic delivery system into its business operation must decide for itself which technology is best for it to adopt and implement and, it must satisfy itself that by adopting such technology it will keep the insurance company fully in compliance with applicable provisions of the Insurance Act and regulations and ensure the security of the site and that the policy so issued cannot be altered by any other person.

Such positive use of e-technology by the insurance industry is going to give it a greater impetus and help in easier, faster and convenient marketing.

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

Where are the Customers?

G. V. Rao

New channels are all very well, says the author. But have we harnessed the true power of the traditional channels? The former should be used more as support systems for the latter to achieve desired growths in insurance penetration.

Initiatives taken to raise supply side

Liberalisation of the insurance sector that took place in the year 2000 has enhanced the availability of the insurance products by permitting private players to enter the market. It was expected that these new suppliers would create a fresh demand for insurance products and in the process spread the insurance net wider to cover more customers and raise the level of insurance penetration (defined as the percentage of gross premium to GDP).

The Insurance Regulatory and Development Authority (IRDA), through issuance of regulations, has permitted a variety of distribution channels to enter the marketing process expecting that they would stimulate a greater demand for purchase of insurance products. An extensive public awareness drive was also initiated by the IRDA on TV, radio and in the print media to make the uninsured know the benefits of insurance. The IRDA has also stipulated obligations on insurers to develop a minimum business annually from the social and rural sectors.

Has demand for insurance gone up?

Has the demand for insurance significantly gone up due to these initiatives? How effective are the existing distribution channels in spreading risk awareness among the public to raise the levels of insurance penetration? The insurance penetration in the non-life sector has gone up from 0.49 per cent in 1999-2000 to 0.58 per cent in 2002-03 in a span of three years. This increase is also largely due to hefty upward revisions in tariff rates in Motor business in 2002-03. Even Kenya and Indonesia have comparatively higher levels of penetration than that of India.

What is hindering the distribution channels from playing a more aggressive marketing role? To increase the level of penetration, do we need additional distribution channels? Is it the structure of distribution or the reluctance of the insurers that is responsible for the sluggish demand for insurance?

What is holding up demand creation?

This article proposes to discuss the above issues and highlight what should really change in the strategies, attitudes and goals of insurers for demand for insurance to pick up. Growth in the insurance sector has been driven for the last few decades by the financial institutions (in Fire, Engineering and Marine) and the statutory laws and customers (Motor and Health.) Insurers have harvested growth without contributing to it in a big way. It was as risk awareness had to be created in them, new affordable products designed and more time was required to farm and harness them. Insurers have had no time for the pioneering efforts of creating new customers and new markets. Farming the markets already created and dealing with existing customers has kept them fascinated and given them a relatively easy time.

Cost-effective direct marketing efforts can still be pursued but it requires new models of business creation and distribution.

direct marketing right through with their own offices as the distribution centres. The agency concept in non-life business was systematically downgraded and has survived because it could not be eliminated under law. Now, to go back to accepting and developing agents and corporate agents as an important part of marketing calls for a total change in the mindset which the insurers are finding as a bitter pill to swallow.

The target group of customers pursued by all insurers is the corporates, as they have sizeable premium to offer that is compulsorily insurable. Personal insurances of affluent individuals in urban and semi-urban areas, retail segments like the shopkeepers etc. and insurance for rural population are mostly voluntary and optional in nature. These are left out of the insurance net;

The insurers who, in their eagerness to build volumes of premium rather quickly, have been content so far to pursue contacts with corporates and have built their marketing and distribution structures to cater to them. The responsibility for creating risk awareness and pioneering into new areas of markets has been left to the potential uninsured customers themselves. Even the rural insurance business has developed because of persistent Government initiatives

The mindset, essentially bureaucratic and reactive for decades, has refused to move into proactive entrepreneurial mode. The poor premium growth rate of 13 per cent in 2003-04 down from the previous 22 per cent in 2002-03 and 18 per cent in 2001-02 should hopefully spur new enthusiasm to spring in them.

But cutting down managerial and marketing staff by the public players is a sure signal, that cost-cutting and efficient operations are the basic objectives to be pursued and not certainly widening the market.

What role do the distribution channels have to play in this emerging environment? Cost-effective direct marketing efforts can still be pursued but it requires new models of business creation and distribution. We will discuss this later.

Distribution channels, insurers and the demand side

The existing distribution channels are direct marketing (by company

officials), agents, corporate agents and brokers. The public players who have monopolised the market for the last three decades have relied on direct marketing and interface with customers as a means of meeting the demand for insurance products. For penetration levels to improve it is not only the proficiency and effectiveness of the distribution system but the strategy and attitude of insurers of how they would want to reach out to their existing and potential customers that is more important. The organisation and stimulation of the distribution system is the sole responsibility of the insurers.

How professional are the distributors is the next question. Yet again, it is the responsibility of insurers to upgrade the knowledge levels and sales skills of the agents and corporate agents. Brokers, who represent the insured customers, are expected to possess as much knowledge and negotiating skills as the insurers themselves. Are they qualified to render such professional services to the contracting parties?

Unless the insurers changed their mindset towards agents and brokers, the present distribution channels will continue to function with the handicap of lack of total acceptance necessary for any distribution system to be effective. Insurers should use the available distribution channels to expand the market horizontally in segments that have not been touched till now by professionalising the agency force.

Agents and Corporate Agents

Insurance is a complex and technical business but vitally necessary for entrepreneurship to flourish and financial security to be assured. Since the insurance products are intangible and contingent in nature promising future delivery of benefit and service, a good deal of trust between the seller and buyer is necessary. The number of covers available for sale is vast. Agents and corporate agents who interface with customers need to demonstrate that they possess the technical and sales ability to sell and service insurance covers. Customers regard them as experts in their line of business. Insurers at present are not doing enough to train their agents in making them live up to this image. What kind of risk management solutions are the agents good at delivering? Can they deliver what insurers expect them to deliver? If not, what should insurers do to enable them to be truly representative?

Insurers should train agents keeping the target customer groups that form the prospect base of individual agents in mind. The present omnibus training for a few hours in a classroom is not enough. They also need to be mentored till they gain confidence in their expertise and ability to deal with prospects on their own. Retraining and instilling in them a feeling of being wanted as a part of the organisation is important for the agent to strive to do his best. The accountability for this rests with the insurer more than the agent.

> In a competitive environment the insurers have to redraw their structure to give primacy to selling, servicing and creation of new markets.

Brokers

Brokers have been brought into the distribution channel recently but with the objective of making the customer feel that he is getting independent professional advice in his best interests. But since there is a strong tariff structure, making insurance policies seem more as commodities, a broker is unable to act as a full-fledged professional.

Since most covers bought are compulsory as collateral and as there is no rate differential for superior risk management under the tariff the whole transaction is determined by net costs to the corporate. Unless the tariffs are dismantled, a broker's role is restricted to capitalising on the mistakes and errors of insurers rather than concentrating on areas of risk management. This situation is hardly likely to bring insurers and brokers any closer to work in cooperation for the best interests of the customers.

Bancassurance

Banks have been allowed to become corporate agents of insurers. A large number of banks have signed MOUs with major insurers. No enlightened thought seems to have been given of how to translate the combined synergy for the convenience of the bank's customers. The insurance transaction is seen only as a business arrangement for both at the expense of the customer. Unless the banks perceive the arrangement as a benefit for their customers and not mainly for its commission earning capability, the banks will find it difficult to deal with conflict of interest situations.

It is for the insurers to make the new arrangement work smoothly by developing a business model that works in the best interests of all the parties. Sufficient preparatory work visualising the likely problems that will crop up is necessary for this channel to perform at its potential.

Direct Marketing

Insurers seem more comfortable with 'direct marketing' through companies' officials. Selling activity is now entrusted mainly to Development Officers. Corporate customer building is entrusted to managers of branches and divisions. These managers are also entrusted with a variety of other important duties of which marketing and selling is only one of them. Their

current primary role is managing and not marketing.

In a competitive environment the insurers have to redraw their structure to give primacy to selling, servicing and creation of new markets. Unless the structure fixes accountability for creation of new markets and marketing as key performance areas of exclusive officials, the distribution channels will suffer neglect and have to rely on their own capabilities without corporate support.

The insurers have their data captured to monitor the performances of their branches and divisions, the distribution centres of their policies. But they singularly lack data on their individual customers in respect of their profiles, performance and profitability. How then can they ever become customer focused, if they do not have customer related information with them on their computer screens? The immediate need is to build customer profiles so as to study the missing gaps in insurance buying and develop models to sell to other uninsured public.

Call centres

One of the cost effective ways for locating prospects is to make available customer data, particularly for personal lines, of the motor vehicle owners, to call centres to mail product literature to existing customers and to seek their preference on telephone for buying additional covers they currently do not have. Once the interested prospects are located the direct marketing specialists can take over.

The use of technology and modern marketing methods used in banks to solicit customers can certainly be implemented in insurance sector as well.

Internet usage

The Internet can be used to offer supportive services in insurance, like the proposal forms, claim forms, claim intimations and e-mail correspondence. The purpose is to encourage e-communication between the insurers and their customers. For this computer literacy levels in the offices of insurers has to be 100 per cent, which sadly is not the case. Even departmental communications are exchanged on costly faxes and mobile phones.

Over a period of time customers would deal with insurers on Internet for many of their requirements. Insurers have the responsibility to be ready when this happens and also encourage their customers to use Internet communication.

Conclusion

There are a very large number of non-customers outside the net of insurance. Bringing such non-customers into their hold is a marketing challenge for insurers. They should have the necessary insurance products at affordable rates for them. They should also have the right, professionally competent distribution channels to reach them.

The buck comes back to insurers to make the existing channels function more effectively.

Insurers own the channels of agents and corporate agents and direct marketing. How effective are insurers in harnessing them for their best potential in their self-interest? The buck comes back to insurers to make the existing channels function more effectively. Creation of risk awareness and stimulating a desire in non-customers to buy insurance as a mechanism of financial security is primarily the responsibility of the insurers.

Alternate distribution channels to reach out to non-customers, particularly in the rural and semi-urban areas,

should be considered. For this, the licensing mechanism of agents and corporate agents by IRDA should be done away with; and the choice of selecting them should be left to the insurers. The agents need registration but not licensing. In a free market it is for insurers to take responsibility for their agents.

Where are the customers? Make the process of finding them simpler. Let the insurers rethink what it is that they ultimately want. If they want customers, they should locate them and then come closer to them. The distribution channels can only be as effective as the insurers want them to be; as effective as they are themselves in creating customers – the only purpose of their existence as corporate entities.

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प्रकाशक का संदेश

सडक पर चलना एक चुनाव नहीं है लेकिन यह बिना जाने, यात्रा के लिए अनिवार्यता है। ऐसा उद्योग जो अपनी पुन: पहचान तथा बाजार बनाने में लगा है। इसने उद्यम किये हैं दूरस्थ ग्रामीण बाजार में जाने के तथा अच्छे शहरी बाजार के लिए भी जो एक अच्छा अनुभव है।

आईआरडीए जर्नल के इस अंक में वितरण के विभिन्न विकल्पों पर चर्चा की गई है। जीवन बीमा विक्रय के लिए एजेन्ट सबसे महत्वपूर्ण चैनल रहेंगे ही साथ ही गैर गैर जीवन बीमा के व्यक्तिगत बीमा में भी योगदान देगें, ग्राहक तक पहुँचने के लिए कुछ अन्य ढंग भी महत्व प्राप्त कर रहे हैं जिससे बीमा भेदन के निम्न स्तर को दूर किया जा सके।

मुझे इस बात में कोई संदेह नहीं है कि बीमा उद्योग में सभी यह देखना चाहेगें कि बीमा के विकास के साथ देश की वित्तिय सुरक्षा बढे और मुझे विश्वास है कि यह इन अकांशाओ का पोषण केवल वाणिज्यक हितों के लिए नहीं वरन् सामाजिक सुरक्षा तथा समृद्धि की अकांक्षाओं को पुरा करने के लिए होगा। इस प्रकार की छलांग लगाने के लिए प्रत्येक प्रयत्न की गणना होगी और प्रत्येक वह विचार जो कुछ हजार नये गाहक पैदा कर सके मदद करेगा। कोई यह नहीं जानता कि कौन सा चैनल कल ग्राहक के लिए सबसे बडा अंशदाता बनेगा।

जब उद्योग बीमा बेचने के नये तरीकों को खोज रहा है हम भी प्रणाली तथा विधि प्रश्न जो उ खडे है पर ष्टिपात कर रहे है। निसेदेह कंपनियाँ इन को युक्तिपूर्वक निर्वाह कर रही है।

यह विषय तीन निकटतम अन्तर्निहित विषय जिनका सम्बन्ध उत्पाद तथा ग्राहक से सामने आता है। ग्राहक की अपेक्षाएँ नए उत्पान तथा वैकल्पिक चैनल जिन्हें ग्राहक तक पहुचाना है।

अगला अंक पूरी तरह से नए क्षेत्र पर आधरित होगा वह सबसे अधिक उगता हुआ,क्षमतावान उद्योग है जिसे देश को देखना है. पेंशन

अब तक पैंशन बाजार पर सीमित ध्यान वित्तिय सेवाएँ उपलफ्रध करवाने वालों द्वारा दिया गया है जो सेवा निवृत समाधान प्रस्तुत करते हैं। इसमें बीमा कंपनियाँ भी शामिल हैं।

यह विश्वास करना मुश्किल है कि भविष्य सेवानिवृति समाधानों से जुडा है। बीमा कंपनियो को वार्षिकवृत्ति पर एकाधिकार है। उन्हें कडी की अन्य गतिविधियों में जिनमें सेवानिवृति समाधान तथा पालसी प्रस्ताव शामिल है सरकार के सामने है।

पिछले दो अंको सेद जर्नल आपके समक्ष पेंशन सैक्टर में परिवर्तन का वृतचित्र प्रस्तुत कर रहा है अगले माह हम पैंशन बाजार के कार्य तथा भविष्य पर विस्तृत ष्टि डालेगें ।

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दुकान पर उपलब्ध

के. नित्य कल्याणी

यह एक उत्पाद के लिये सर्वथा उचित समय है। ग्राहक जिस समय उत्पाद चाहता है, सेवा प्रदाता उसे उपलब्ध करा देता है और मूल्य भी बिल्कुल उचित होता है।

आज का समय इकाई-संबद्ध उत्पादों का है। इक्विटी बाजार तेजी से बढ़ रहे हैं और ब्याज दर घटती जा रही है। जीवन बीमा क्रेता, जो अपनी पॉलिसी से निवेश वापसी चाहने का आदी हो गया है, इस अवसर की ओर हर्षित होकर आता है।

बाजार माध्यम की तुलना में केवल उत्पाद एक जोखिम सुरक्षा से रहित है। एक पारंपरिक बीमा पॉलिसी में बीमा कंपनी दो जोखिम लेती है। पहला बीमाकृत व्यक्ति के जीवन पर और दूसरा निवेश वापसियों पर। इकाई-संबद्ध उत्पाद के मामले में बीमा कंपनी समग्र रूप से बीमाकृत व्यक्ति के निवेश जोखिमों से गुजरती है।

इकाई-संबद्ध पॉलिसियों के मामले में प्रीमियम बीमा अधिनियम, 1938 की धारा 27 के अंतर्गत नियंत्रित निधियों की तरह नहीं है, जो अधिक परिवर्तनशील निवेशों, जैसे इक्विटी मार्केट के साथ मिश्रित पूर्ण रूप से सुरक्षित और तुलनात्मक रूप से अर्थसुलभ पत्राधान सुनिश्चित करके पॉलिसीधारकों के हितों की रक्षा चाहती है। पारंपरिक जीवन उत्पादों के मामले में निवेशों के अधिकतम 35 प्रतिशत हिस्से को पूंजी बाजार माध्यमों में निवेश करने की अनुमति देते हुये एक बड़ा हिस्सा विभिन्न श्रेणियों के अंतर्गत सरकारी प्रतिभूतियों में निवेश किया जाना चाहिये।

इकाई-संबद्ध पॉलिसी निधियों का निवेश इस श्रेणी के उत्पादों के लिये आईआरडीए के निवेश नियमनों के अनुसार किया गया है। यहां निधियों का 75 प्रतिशत तक अनुमोदित निवेशों में निवेश किया जा सकता है (जिसमें पूंजी बाजारों में इक्विटी व ऋण माध्यम शामिल हैं, जो धारा 27 ए और 27 बी के अंतर्गत स्थित शर्तों को सुनिश्चित करते हैं), जबकि शेष 25 प्रतिशत का निवेश अनुमोदित निवेशों से हटकर किया जा सकता है। ग्राहक को उत्पाद की ओर अपनी आखें खुली रखकर जाना चाहिये, जैसा कि कंपनी करती है।

आज अंतर-कंपनी ग्राहकों के लिये कंपनी शासन मामलों, यौन उत्पीड़न खतरों, दायित्व उत्पादों, ऋणदाता के उत्तरदायित्व, शेयरधारकों के प्रति उत्तरदायित्व, लाइसेंसिंग शर्त (बीमा आढ़तियों के लिये) या बाजार दबाव (पेशेवर चिकित्सकों और अस्पतालों के लिये लापरवाही बीमा) के तौर पर व्यावसायिक क्षतिपूर्ति सुरक्षा से नियत उत्तरदायित्व उत्पादों का भी समय है। इसमें से अधिकतर ग्राहक चालित हैं और ग्राहक वैधानिक आवश्यकताओं या उनके वादप्रिय ग्राहकों से चालित होता है। कुछ उत्पाद विस्तारों और नवीकरणों को इसके साथ प्रयोग किया गया तथा यह किसी भी परिस्थिति में विपणन चाहते हैं। जैसा कि मौसम बीमा उत्पाद, जिसका आईसीआईसीआई बैंकर भारतीय कृषि बीमा कंपनी के साथ मिलकर परीक्षण कर रहा है, इससे अधिक पीछे नहीं है।

अस्पताल चिकित्सा बीमा दावों को संभालने के लिये तृतीय पक्ष प्रशासक (टीपीए) का आरंभ उत्पाद विस्तारों में से एक है। यह पद्धति अभी भी भारी परेशानियों से गुजर रही है तथा "नगदरहित" पॉलिसियां फ़ीडबैक हैं, जिसमें भुगतान करने के बाद प्रतिपूर्ति मांगने की अभी तक जारी पद्धति की जगह अस्पताल के बिल का भुगतान बीमा कंपनी द्वारा सीधे स्वास्थ्य सेवा प्रदाता को किया जाता है। इस पद्धति को अभी तक कार्यरूप नहीं दिया गया है।

किसी भी नये उत्पाद के पीछे (या किसी वर्तमान उत्पाद का आहरण) फ़ाइल अवस्थित होती है तथा यह आईआरडीए द्वारा बनाई गई प्रक्रिया का उपयोग करता है। एक बीमा कंपनी को समयावधियों, लाभों, अपवर्जनों व मूल्य निर्धारण सहित व्यापक उत्पाद सूचना उपलब्ध करानी चाहिये। पॉलिसी के प्रकार के अनुसार (उदाहरण के लिये इकाई-संबद्ध) शुल्कों के बारे में विवरण से बताया जाना चाहिये। गैर-जीवन उत्पादों के लिये पुनर्बीमा, अतिरिक्त, अधिबीमा आदि पर भी सूचना दी जानी चाहिये। दोनों श्रेणियों को दावों की ष्टि से मूल्य निर्धारण पूर्वानुमान, व्ज्ञ व पूंजी तथा शोधन क्षमता आवश्यकताओं सहित वित्तीय प्रस्तुतीकरण देना चाहिये।

इसके अतिरिक्त, कंपनी के नियुक्त बीमांकक को यह अनुमोदित करना चाहिये कि "उत्पाद की प्रीमियम दरें, लाभ, शर्तें व नियम व्यवहारक्षम और समर्थ हैं, पूर्वानुमान यथोचित हैं तथा प्रीमियम दरें सही हैं।

नियुक्त बीमांकक किसी भी बीमा कंपनी का एक विशिष्ट प्रकार का कर्मचारी है (आज भारत में एक साधारण बीमा कंपनी में वह एक सलाहकार हो सकता है)। नियुक्त बीमांकक एक बीमांकक के अपने पेशे के रूप में अपने पेशेवर संस्थान भारतीय बीमांकन सोसायटी (एएसआई) की आचार संहिता का पालन करने के लिये प्रतिबद्ध है। इसके अतिरिक्त, कंपनी में उसकी नियुक्ति आईआरडीए द्वारा उसकी "उपयुक्त और समुचित" प्रक्रिया (किसी भी बीमा कंपनी में कुछ शीर्ष स्तर की नियुक्तियों के लिये अनुवीक्षण) के अंतर्गत स्पष्ट है। कंपनी में आईआरडीए के नेत्र व कान बनकर रहना उसकी ड्यूटी है तथा मूल्य निर्धारण, शोधन क्षमता, पूंजी आवश्यकताएं, लाभदेयता तथा संबद्ध अनुपालन मामलों से संबंधित कंपनी की कार्यप्रणाली के बारे में निदेशक मंडल के सदस्यों को पूरी तरह से अवगत रखना उसका दायित्व है।

अब हम फ़ाईल एवं उपयोग प्रक्रिया पर पुन: वापस आते हैं। भारत में साधारण बीमा के मामले में 80 प्रतिशत उत्पाद शुल्कदर सलाह समिति (टीएसी) द्वारा निर्धारित शुल्क दर के अंतर्गत आते हैं, इसलिये यह सिर्फ़ उन उत्पादों के लिये है, जो नये उत्पादों द्वारा अपनाई जा रही शुल्क सूची के अंतर्गत नहीं आते हैं। नये शुल्क दर उत्पादों या वर्तमान शुल्क दर उत्पादों के आधुनिकीकरण के लिये टीएसी फाईल के अनुसार जाती है तथा अन्य किसी बीमा कंपनी की भांति ही औपचारिकताओं का उपयोग करती है।

शुल्क दरों को टीएसी की ओर से नियुक्त किसी बीमांकक द्वारा इन दरों को लागू करने से 30 दिन पूर्व अपवर्जनों सहित पॉलिसी व्याख्या के साथ प्रमाणित किया जाना चाहिये। उत्पादों के आहरण के संबंध में कंपनियों के लिये टीएसी पर समान औपचारिकताएं लागू होती हैं।

विश्वभर में अधिकतर बीमा नियामकों द्वारा पालन की जाने वाली फाईल व उपयोग प्रक्रिया कई उद्देश्यों के लिये उपयोग में आती है। इनमें से कई का अंतिम उद्देश्य यह सुनिश्चित करना है कि पॉलिसीधारकों के हित सुरक्षित हैं। यदि उत्पाद की शर्तें व लाभ कुछ लाभों के लिये निर्धारित न्यूनतम मानकों के अनुसार ग्रहणीय हैं तो नियामक इसे जांच के द्वारा पूरा करता है।

मूल्य निर्धारण इस ष्टि से मूल्यांकित होते हैं कि क्या यह बीमा कंपनी के लिये लाभप्रद उत्पाद होगा। यह एक पहेली देने के समान होगा कि नियामक इस बात का ध्यान रखे कि उत्पाद लाभ देता है या नहीं। एक बीमा उत्पाद वास्तव में दावे के समय ही दिया जा सकता है।

फाईल व उपयोग प्रक्रिया का एक और लाभ यह है कि नियामक मूल्य निर्धारण तथा लाभों की जांच पूरे बोर्ड में कर सकता है। यह प्रीमियम व अन्य शुल्क वसूलने हेतु कंपनियों के लिये स्वाभाविक संतुलन (लेकिन एक प्रतिस्पर्धी बाजार, जहां ग्राहकों के पास बीमा कंपनियों का विकल्प है, द्वारा उपलब्ध कराये गये एक उत्पाद से संभवत: गौण रूप में) के रूप में कार्य करती है।

फाईल व उपयोग प्रक्रिया के माध्यम से प्राप्त सूचना मूल्य निर्धारण व दर सूचना तथा उद्योग के बारे में लाभप्रदता संकेत संचित करती है, जो बाजार की प्रकृति को समझने में प्रणाली की मदद करते हैं। आखिरकार यह पुरानी प्रवृत्तियां और अनुभव हैं, जिसने बीमा व्यापार की रीढ़ बनाई है।

“ कुछ तो लोग कहेंगे ”

भारत में विश्व के सबसे बडे पेंशन बाजार बनने की क्षमता है।

श्री संजय सचदेवा, प्रबन्ध निर्देशक, प्रिंसिपल म्युचुवल फंड,फाइनेंशल ग्रुप की सहायक कंपनी,अमेरिका कंपनियों को सबसे अधिक सेवानिर्वति योजना उपलबध करवाने वाली कंपनी

यह अधूरा पूर्ण निर्णय है। हम स्वीस री के सम्बन्ध में निर्णय की प्रतिक्षा कर रहे हैं जिसने वर्लड ट्रेड सेन्टर के संबन्ध में अधिकत्तम आवरण प्रदान किया था। हमारे भविष्य की कोई टिप्पणी नहीं है जूरी इसमें लगी ही हुई है।

श्री हावर्ड रोबिन्नस्टाइन, (वर्लड ट्रेड सेन्टर के पट्टाधारक) लेरी स्लिवर स्टाइन के प्रवक्ता, जो निर्णय के अनुसार हारने वाले पक्ष में थे।

पिछले कुछ वर्षो में बीमा बाजार ने कई हानियाँ देखी हैं, उच्च मूल्यवृद्धि, और अब रिकार्ड लाभ, सुलभ उत्तरवर्तन। आप मागँने के लिए दोषी हो सकते हैं कि इस धरती पर क्या हो रहा है ? हमने हाल ही के वर्षो मे उच्च उतार-चढ़ाव के बीमा बाजार को देखा है जो व्यवसायों के लिए बुरी बात है। उतार-चढ़ाव का अर्थ है कि बीमा क्रय कर्ता बीमा की लागत वहन नहीं कर सकते

लार्ड पीटर लेविन, अध्यक्ष, लायड्स आफ लंदन

आज विनियामक कि मुख्य चिंता हैल्थ बीमा का विकास है । अब तक हैल्थ बीमा का विष्णन गैर जीवन बीमा कंपनियों द्वारा किया जाता था। जीवन बीमा कंपनियों ने नाजुक बीमारी उत्पादों के अतिरिक्त इस क्षेत्र में अधिक रूचि नहीं दिखाई है । भारत में खुदरा बीमा व्यवसाय जीवन बीमा कंपनियो की विशेषता रही है। और जब तक हम जीवन बीमा कंपनियों को इस तरफ आकर्षित नहीं करेगें भारत में हैल्थ बीमा का विकास धीमा ही रहेगा।

श्री टी. के बैनर्जी,
सदस्य (जीवन) आईआरडीए

जो आप देखते हैं वह बहुत सर्जक प्रयत्न दौहरी वसूली का है। इससे जो सबक सीखा जा सकता है वह है सर्जक वकालत अब तक आपके काम आती रही लेकिन आगे नहीं।

श्री डेविड बोइस, लायड्स लंदन के वकील वर्ड ट्रेड सेन्टर मामले में जिसमें जूरी ने बीमाकर्त्ता के पक्ष में निर्णय दिया

पूँजीवाद का डीएनए बीमा है।
श्री जो प्लूमरी, अध्यक्ष, विल्स, दुनिया के तीसरे सबसे बडे बीमा दलाल

चिंतन का एक नया पथ

- राष्ट्रीय जीवन बीमा कंपनी द्वारा उत्पाद रूपांकन में नवीन प्रक्रिया और मूल्य निर्धारण

दिनेश चंद्र खंसिली

जीवन बीमा बाजार में नवीन प्रक्रिया साधारणत: निजी कंपनियों द्वारा उठाये गये कदमों से प्रभावित रहती है। आज भारतीय जीवन बीमा बाजार गतिशील है। निजी जीवन बीमा कंपनियों के अमेरिका, यूके, जर्मनी, कनाडा, आस्ट्रेलिया, फ्रांस तथा साउथ अफ्रीका में संयुक्त उद्यम साझेदार हैं और स्वाभाविक रूप से इन देशों के जीवन बीमा बाजार की कार्यप्रणालियां इन निजी जीवन बीमा कंपनियों द्वारा हमारे देश में उपलब्ध कराये जाने वाले उत्पादों में प्रतिबिंबित होती हैं।

यह सभी उत्पादों में प्रतिबिंबित होती है, चाहे वह व्यक्तिगत जीवन उत्पाद, पेंशन उत्पाद, विभिन्न राईडर्स, ग्रुप उत्पाद, इकाई सहबद्ध उत्पाद, वैश्विक जीवन उत्पाद या फिर स्वास्थ्य उत्पाद/राईडर्स हो। राष्ट्रीय बीमा कंपनी भरतीय जीवन बीमा निगम (एलआईसी) ने भी नवीनीकृत उत्पाद लाकर जीवन बीमा बाजार को अधिक प्रतिस्पर्धी बनाकर इस बाजार में योगदान दिया है।

अभी काफ़ी दिन नहीं हुये, इसने महिलाओं के लिये एक नया उत्पाद "जीवन भारती" प्रारंभ किया। हाल ही में इसने "जीवन सरल" नामक एक नया उत्पाद प्रारंभ किया, जिसे न केवल भारत, बल्कि अधिकतर विकसित देशों में भी एक अपूर्व उत्पाद माना गया। इस उत्पाद की मुख्य विशेषता यह है :- जीवन बीमा की दुनिया में आज धर्मादाय उत्पाद (बिना लाभ वाली) मृत्यु या पूर्णता के कारण निर्गम पर उतनी बीमाकृत राशि का वचन देते हैं, जो साधारणत: प्रीमियम सारणी में प्रीमियम के रूप में भुगतान की जाती है।

"जीवन सरल" में मेच्युरिटी मूल्य प्रवेश आयु तथा समयावधि पर निर्भर होता है, लेकिन मृत्यु जोखिम सुरक्षा आयु के भेदभाव के बिना समान है। यह उत्पाद मूल्य निर्धारण संकल्पनाओं में परिवर्तन तथा प्रतिस्पर्धा के इस दौर में कुछ नया प्रस्तुत करने के एलआईसी के उत्साह को दर्शाता है।

यहां यह प्रयास रहा है कि निर्णय लेने को ग्राहकों के लिये सरल बनाया जाये, विशेषकर उनके लिये जो वेतन बचत योजना चुनते हैं। यह नियोक्ता-कर्मचारी ग्रुप के एक वर्ग के लिये ग्राहक हितैषी प्रतीत होता है, जिसका आज तक एलआईसी में अभाव था।

कुछ आयु वर्गों तथा समयावधि के लिये प्रत्येक 100 रुपये महीना प्रीमियम पर नमूना मेच्युरिटी बीमाकृत आश्वासित राशियां नीचे दी जा रही हैं :

इस उत्पाद का बिक्री साहित्य उत्पाद की उच्चतम सुरक्षा, सुगम वापसी, नकदी और विचारणीय लचीलेपन का वर्णन करता है। बीमा कराने वाले व्यक्ति की मृत्यु के पश्चात बीमा कराने वाले के नामिती/नामितियों को दिये जाने वाले लाभ का वायदा मासिक प्रीमियम का 250 गुना के अलावा अतिरिक्त/राईडर प्रीमियम को छोड़ प्रीमियमों की वापसी तथा प्रथम वर्ष प्रीमियम के अलावा, अगर है तो, अतिरिक्त लोयलिटी के रूप में किया जाता है।

यदि जीवन बीमा कराने वाला व्यक्ति पॉलिसी की समायावधि तक जीवित रहता है तो वह प्रत्याभूत मेच्युरिटी राशि के अलावा, यदि है तो, अतिरिक्त लोयलटी पाता है।

उनकी वर्तमान योजनाओं के अनुसार इसमें कुछ विशेषताएं जैसे प्रत्याभूत अभ्यर्पण मूल्य (जीएसवी), नि:शुल्क समय बंदी, प्रीमियम के भुगतान के लिये रियायत अवधि, ऋण, पॉलिसी का पुनर्प्रवर्तन आदि हैं।

यद्यपि पॉलिसी ने यह घोषित कर दिया है कि विशेष अभ्यर्पण मूल्य क्या होने चाहिये, इसलिये पारदर्शी ष्टिकोण से यह एक नई विशेषता और बिन्दु है, क्योंकि ग्राहक को समाप्ति शर्तें अभ्यर्पण के समय ही बताई जाती हैं। जीवन सरल के मामले में विशेष अभ्यर्पण मूल्य निम्नलिखित (अ) और (आ) के अनुसार होंगे :

प्रवेश के समय आयु	पॉलिसी की अवधि			
	10 वर्ष	**15** वर्ष	**20** वर्ष	**25** वर्ष
20	11,156	19,628	28,039	36,839
30	11,053	19,300	27,345	35,492
40	10,431	17,839	24,598	30,854
50	8,442	13,444	16,164	-

अ) मितीकाटा मूल्य या संचित मूल्य, जैसा भी मामला हो, निम्नलिखित होने चाहिये :

चार वर्ष के प्रीमियमों से कम का भुगतान करने पर मेच्युरिटी राशि के 80 प्रतिशत का आश्वासन, चार या अधिक वर्ष, लेकिन पांच वर्ष से कम के प्रीमियम का भुगतान करने पर मेच्युरिटी राशि के 90 प्रतिशत का आश्वासन तथा पांच या अधिक वर्षों के प्रीमियम का भुगतान करने पर मेच्युरिटी राशि के 100 प्रतिशत का आश्वासन दिया जाता है।

इस उद्देश्य के लिये आश्वासित मेच्युरिटी राशि पॉलिसी के अंतर्गत प्रीमियमों के किये गये भुगतान की अवधि के तदनुरूप होगी। यदि प्रीमियमों का

भुगतान एक वर्ष की समयावधि तक किया गया है, तो आश्वासित मेच्युरिटी राशि पर गणितीय अंतर्वेशन के अनुसार कार्य किया जाएगा। यदि समयावधि पॉलिसी के प्रारंभ होने और अभ्यर्पण की तिथि तक की समायावधि, जो उस समयावधि से भी कम है, जिसके प्रीमियमों का भुगतान किया जा चुका है, से आगे बढ़ जाती है तो उपर्युक्त राशि अगले किश्त प्रीमियम की नियत तिथि से अभ्यर्पण की तिथि तक बट्टागत कर ली जाएगी। यदि समयावधि पॉलिसी के प्रारंभ होने और अभ्यर्पण की तिथि तक की समयावधि, जो उस समयावधि से भी अधिक या बराबर है, जिसके प्रीमियमों का भुगतान किया जा चुका है, से आगे बढ़ जाती है तो उपर्युक्त राशि प्रथम भुगतान नहीं किये गये प्रीमियम की नियत तिथि से अभ्यर्पण की तिथि तक की समयावधि तक ब्याज से संचित कर ली जाएगी। जिस समयावधि के लिये उक्त राशि बट्टागत या संचित की जाएगी, वह संपूर्ण महीनों में ली जाएगी तथा एक महीने के भाग को नजरअंदाज किया जाएगा। बट्टागत या संचित, दोनों में से जो भी मामला हो, करने के लिये उपयोग में लाई जाने वाली ब्याज दर निगम द्वारा प्रत्येक वित्तीय वर्ष के प्रारंभ पर घोषित की जाएगी।

आ) निगम के मूल्यांकन परिणामों को 31 मार्च को घोषित करते समय घोषित किया जाने वाल लोयलटी परिवर्धन, यदि है तो, अभ्यर्पण के ठीक पहले होगा।

यह पॉलिसी प्रदत्त मूल्य भी देती है :

कम से कम पूरे तीन वर्ष के प्रीमियमों का भुगतान किया जा चुका है और कोई अनुवर्ती प्रीमियम का नियत भुगतान नहीं किया गया है तो पॉलिसी पूरी तरह से अमान्य नहीं हो जाती, बल्कि घटाई गई राशि की एक प्रदत्त मूल्य पॉलिसी के रूप में रहती है। ऐसी पॉलिसियों के अंतर्गत मृत्यु/मेच्युरिटी पर दिया जाने वाला लाभ उतने वर्षों पर निर्भर होगा, जितने वर्ष प्रीमियमों का भुगतान किया जाएगा।

इस पॉलिसी में विकल्प हैं, जिसे व्यक्ति की आयु/समयावधि और स्वास्थ्य की स्थितियों के आधार पर राईडर्स अतिरिक्त भुगतान कर चुन सकते हैं-

- दुर्घटनावश मृत्यु और अशक्तता लाभ
- टर्म एश्यूरेंस लाभ

पॉलिसी के अंतर्गत अन्य लाभ हैं तथा उसमें से कुछ नई विशेषताएं गठित करते हैं। इसमें सम्मिलित हैं :

आटो कवर :

यह योजना पॉलिसी के अस्तित्व में आने के तीन वर्ष या इससे अधिक समय बाद 12 महीने का आटो कवर उपलब्ध कराती है। यह एक नया आयाम है, जो इससे पहले जनरक्षा योजना के लिये एक अलग रूप में उपलब्ध था।

लचीली समयावधि :

पॉलिसीधारक अधिकतम समयावधि का चयन कर सकते हैं, परंतु वे बिना किसी अभ्यर्पण जुर्माना या हानि के किसी भी समय अभ्यर्पण कर सकते हैं। लचीली समयावधि भी एक नया आयाम है, जो वर्तमान उत्पादों में उपलब्ध नहीं था।

आंशिक अभ्यर्पण :

यह योजना चौथे वर्ष के बाद से कुछ शर्तों पर आंशिक अभ्यर्पण की अनुमति देती है, इससे पॉलिसी के अंतर्गत वार्षिक प्रीमियम में कटौती तथा मेच्युरिटी व मृत्यु लाभ की राशि में तदनुरूप कटौती के रूप में प्रभाव पड़ेगा। जिस राशि तक वार्षिक प्रीमियम में कटौती की गई है, उससे तदनुरूप अभ्यर्पण मूल्य का अभ्यर्पण के पश्चात भुगतान किया जाएगा। लोचपूर्ण समयावधि और आंशिक अभ्यर्पण होने के कारण पॉलिसीधारक योजना के अंतर्गत काफ़ी अधिक नगदी का लाभ प्राप्त कर सकते हैं।

लोयलटी परिवर्धन :

यह योजना इस शर्त पर लोयलटी परिवर्धन उपलब्ध कराती है कि न्यूनतम समयावधि, जिसके बाद एक पॉलिसी लोयलटी परिवर्धन कमा सकती है, वह 10 वर्ष होगी। यद्यपि यदि पॉलिसी के 10वें वर्ष में मृत्यु होती है तो भी लोयलटी परिवर्धन देय होगा, परंतु मृत्यु के समय पॉलिसी अस्तित्व में होनी चाहिये। लोयलटी परिवर्धन निगम के अनुभव पर निर्भर होगा तथा मृत्यु, मेच्युरिटी व अभ्यर्पण पर इसका भुगतान किया जा सकता है। यह अधिकतम भागीदारी (लाभ के साथ) के लिये एलआईसी के वर्तमान प्रयास के अनुरूप है।

इसलिये यह प्रतीत होता है कि बीमा बाजार को निजी कंपनियों के लिये खोल देने के पश्चात बाजार में नये उत्पाद लाकर दी गई प्रतिस्पर्धा की चुनौती का सामना करने के लिये एलआईसी प्रतिबद्ध है। यह देखना दिलचस्प होगा कि ऐसे नये उत्पादों पर ग्राहक कैसी प्रतिक्रिया व्यक्त करते हैं। अपेक्षा है कि निजी कंपनियां इसका अनुसरण करेंगी तथा ग्राहकों को उत्पादों की वृहद् श्रृंखला उपलब्ध कराकर जीवन बीमा बाजार को और अधिक प्रतिस्पर्धी बनाने के अपने कौशल का विकास करेंगी।

लेखक आईआरडीए के उप-निदेशक (बीमांकक) हैं। यहां व्यक्त विचार उनके अपने हैं। यह लेख आज बाजार में उपलब्ध कराये जा रहे नये उत्पादों में एक प्रवृत्ति का पता लगाने की कोशिश है। यह कोई सर्वांगपूर्ण सूची नहीं है तथा यह लेखक, आईआरडीए या आईआरडीए जर्नल की ओर से कोई प्रत्यक्ष या अप्रत्यक्ष सिफ़ारिश नहीं करता।

क्षेत्रीय नेटवर्किंग की ओर

विकासशील देशों की बीमा कंपनियों तथा पुनर्बीमा कंपनियों के संघ (एआईआरडीसी) द्वारा दिल्ली में आयोजित 14वें विकासशील देशों के बीमा सम्मेलन (आईसीडीसी) में क्षेत्रीय सहयोग तथा क्षमता निर्माण मुख्य विषयवस्तुएं थीं, साथ ही कृषि बीमा, स्वास्थ्य व वृद्धावस्था सुरक्षा और आपदा प्रबंधन उपायों की खोज के लिये आंकड़ों (डेटा) की भागीदारी भी समान रूप से महत्वपूर्ण थीं।

14वें आईसीडीसी का अनुगमन करते हुये एआईआरडीसी के कार्यकारिणी मंडल तथा सदस्यों ने 9 मार्च को आयोजित अपनी साधारण बैठक में जो संकल्प लिये, उनका सार इस प्रकार है :-

कृषि बीमा

विकासशील देशों, जिनकी आर्थिक स्थिति काफ़ी हद तक कृषि पर निर्भर रहती है, में कृषि बीमा काफ़ी महत्वपूर्ण है। विशेषकर, भारतीय कृषि बीमा योजना कृषि बीमा प्रारंभ करने की योजना बना रही किसी भी विकासशील अर्थव्यवस्था को सुढ़ बनाने के लिये एक आदर्श के रूप में प्रस्तुत की जा सकती है।

आईसीडीसी में कृषि बीमा पर प्रस्तुत दो प्रपत्रों को आईसीडीसी के स्थाई सचिवालय के पुस्तकालय में स्थाई संदर्भों के रूप में स्थापित किया जाएगा तथा एआईआरडीसी की वेबसाइट पर भी रखा जाएगा। भारतीय रिपोर्ट को नियमित रूप से, कम से कम प्रत्येक आईसीडीसी के दौरान अपडेट किया जाना है।

स्वास्थ्य और वृद्धावस्था सुरक्षा : सरकार-उद्योग की साझेदारी आवश्यक

स्वास्थ्य सुरक्षा और सेवानिवृत्ति आय हमेशा विकासशील देशों में चिंता के विषय रहे हैं। किसी भी देश विशेष द्वारा अपनाई जाने वाली योजनाओं में बीमा कंपनियों को महत्वपूर्ण भूमिकाएं निभानी होती हैं, चाहे वहां राष्ट्रीय सामाजिक सुरक्षा प्रणाली हो या न हो। सामाजिक तथा आर्थिक सुरक्षा तंत्र, दोनों के किसी भी देश के लिये दीर्घकालीन वित्तीय उद्देश्य होते हैं, इसलिये लाभार्थियों के संबंध में लाभ और सुरक्षा की व्यापक पद्धति अपनाने की योजना का गंभीरतापूर्वक अध्ययन कर लिया जाना चाहिये तथा किसी भी विद्यमान पद्धति का पुनर्गठन करते समय दीर्घकालीन वित्तीय उद्देश्यों को प्रस्तुत करते हुये उस पर ध्यान से विचार किया जाना चाहिये। यहां निजी बीमा कंपनियां सरकार प्रायोजित पद्धतियों के साथ परिपूरक की भूमिका निभा सकती हैं।

उक्त सम्मेलन में प्रस्ताव पारित किया गया कि एक विकासशील देश में राष्ट्रीय प्रणाली की योजना बनाने, उसे प्रारंभ करने या यदि कोई राष्ट्रीय प्रणाली विद्यमान है, तो उसका पुनर्गठन करने में भाग लेने और सहयोग प्रदान करने के लिये सरकार द्वारा बीमा उद्योग को बुलाया जाना चाहिये।

क्षेत्रीय सहयोग के लिये सूचना प्रवाह की आवश्यकता

क्षमता निर्माण और क्षेत्रीय सहयोग कई दशकों से विकासशील देशों के लिये कार्यनीति रहे हैं। यदि सदस्य देशों के बीच क्षेत्रों को समाविष्ट करते हुये सूचना प्रवाह हो तो अधिक प्रभावी क्षेत्रीय सहयोग की योजना बनाई जा सकती है। बीमा हानि सांख्यिकी का संकलन एक सहयोगात्मक प्रयास है, जिस पर नाइजीरिया में 13वें आईसीडीसी में क्षेत्रीय सहयोग प्राप्त करने के लिये एक आवश्यक कदम के रूप में विचार-विमर्श किया गया था। नाइजीरियाई सम्मेलन में यह प्रस्ताव पारित किया गया कि इस डेटा भागीदारी गतिविधि को एआईआरडीए और एआईएसएडीसी से निधियां दिलाकर बढ़ाया जाये, लेकिन यह प्रयास योग्यता प्रारूप समस्याओं में फंस गया और इसलिये दिल्ली में 14वें आईसीडीसी में प्रारूपों का मानकीकरण करने और इसे सभी सदस्य देशों की एक परियोजना बनाने का एक संकल्प लिया गया।

राष्ट्रीय आपदा बीमा योजना की आवश्यकता गहरे संकट के आपदाकारी प्रभावों से निपटना विश्व के सभी देशों की एक गंभीर समस्या रही है, लेकिन विकासशील देशों, जो प्राकृतिक आपदाओं से ग्रस्त रहते हैं और जिन पर कीमत का भुगतान करने से कुप्रभाव पड़ सकता है, के लिये यह अधिक गंभीर समस्या रही है। १४वें आईसीडीसी में इस विषय पर पढ़े गये प्रपत्रों में महाविपत्ति जोखिमों का प्रारूप बनाने तथा आवश्यक राष्ट्रीय महाविपत्ति बीमा योजनाएं बनाने के लिये सिफ़ारिशें प्रस्तुत की गईं। विश्व बैंक के प्रपत्र में की गई सिफ़ारिशें क्षमता निर्माण तथा क्षेत्रीय सहयोग के लिये नियोजित कदमों के अनुकूल हैं।

यह संकल्प था कि राष्ट्रीय तथा क्षेत्रीय ग्रुप अपनी विशेष परिस्थितियों का अध्ययन करें तथा प्रपत्र में की गई सिफ़ारिशों को अपनाने की संभावनाएं तलाशें।

ग्राहकों के लिये नियामक मानकों को सामंजस्यपूर्ण बनाना

वैक्षीकरण सामंजस्यपूर्ण बीमा नियामक मानक चाहता है। सभी बीमा नियमनों का मुख्य उद्देश्य पॉलिसीधारक के हितों की सुरक्षा करना है, इसलिये एआईआरडीसी तथा एआईएसएडीसी ने यह कहते हुये कि कम से कम उनके अंतर्गत आने वाले देशों के लिये नियामक मानकों को सामंजस्यपूर्ण बनाने के लिये मिलकर कार्य करने हेतु वे अपूर्व स्थिति में हैं, यह संकल्प लिया कि इस उद्देश्य के लिये एक संयुक्त फ़ोरम प्रारंभ करके मिलकर काम किया जाए।

स्वास्थ्य बीमा - स्वस्थ भारत का सपना

आलोक गुप्ता

देश में स्वास्थ्य बीमा अधिकतर सार्वजनिक क्षेत्र साधारण बीमा कंपनियों की मेडिक्लेम पॉलिसी के समान है। मेडिक्लेम वर्ष 1987 में प्रारंभ की गई तथा वर्ष 1999 को छोड़ इसमें कोई बड़ा संरचनात्मक फेरबदल नहीं किया गया। 1999 में आंतरिक लाभ उप-सीमाओं को इससे हटा दिया गया। उस फेरबदल ने इसे बीमा कंपनियों के लिये अलाभप्रद बनाते हुये स्वास्थ्य बीमा बाज़ार को गंभीर रूप से क्षति पहुंचाई। इसने नये उत्पाद प्रस्तुत करने की बीमा कंपनियों की योग्यता और इच्छा को भी कम कर दिया - कोई भी उत्पाद वर्ष 1999 के परिवर्तन द्वारा मेडिक्लेम पॉलिसी को प्रदत्त न्यून मूल्य तथा व्यापक सुरक्षा के समतुल्य नहीं हो सकता। बीमा कंपनियां इसके प्रभाव से अभी भी लड़खड़ा रही हैं तथा दावों को अन्य व्यक्ति प्रशासकों (थर्ड पार्टी एडमिनिस्ट्रेटर्स) के द्वारा समाविष्ट करने के प्रयास जोरों पर हैं। यह अभी भी स्पष्ट नहीं है कि इन प्रयासों से दीर्घकालीन धारणीय आधार पर परिणाम प्राप्त होंगे।

प्रस्तुत आलेख देश में वर्तमान स्वास्थ्य बीमा उत्पादों पर दृष्टि डालने तथा ग्राहक ष्टिकोण से आवश्यक अंतराल की पहचान करने का प्रयास कर रहा है।

स्वास्थ्य बीमा जीवन व साधारण बीमा कंपनियों के बीच युद्ध का मैदान रहा है, क्योंकि साधारण बीमा कंपनियों का दावा है कि यह उनका विशेष क्षेत्र है। जो भी हो, जीवन बीमा कंपनियां स्वास्थ्य बीमा उत्पादों के साथ आगे आई हैं, जो प्रकृति से लाभप्रद हैं और जो गंभीर बीमारी या अस्पताल नकद लाभ जैसी जीवन सुरक्षाओं के लिये राइडर्स के रूप में हैं।

गंभीर बीमारी बीमा

गंभीर बीमारी (सीआई) बीमा एक जीवन लाभ है, जिसका उद्देश्य पॉलिसीधारकों को किसी भी आवरित गंभीर या जानलेवा बीमारी की चिकित्सा के लिये एकमुश्त अदायगी करना है। सामान्यत: आवरित की जानेवाली गंभीर बीमारियों में हृदयाघात, पक्षाघात, कैंसर और गुर्दा खराब होना हैं।

गंभीर बीमारी बीमा सबसे पहले दक्षिण अफ्रीका में वर्ष 1960 में इस बात का अनुभव करने के पश्चात विकसित हुई कि इन बीमारियों से पीड़ित कई लोग अक्सर गंभीर आर्थिक संकट में फंस जाते हैं। वास्तविक जीवन परिस्थितियों में गंभीर बीमारी से लड़ते किसी भी व्यक्ति के लिये आर्थिक सहयोग देना उस बीमारी के कारण उसकी मृत्यु होने या उसके शारीरिक रूप से विकलांग होने या मानसिक रूप से विक्षिप्त होने से अधिक महत्वपूर्ण है।

डॉ. मेरियस बर्नार्ड ने लिखा है कि गंभीर बीमारी से पीड़ित मरीज़ तथा उसके परिवार के सदस्य कई बार कर्ज़ के बोझ तले दब जाते हैं और उनकी कमाई की क्षमता भी पहले के मुकाबले घट जाती है। इस कारण जीने का स्तर घट जाता है, परेशानियां बढ़ने लगती हैं और वे आर्थिक रूप से काफ़ी कमजोर हो जाते हैं। यह परिस्थिति भारत में कुछ अलग नहीं होगी।

इसमें कोई आश्चर्य नहीं होगा यदि एक अध्ययन में यह पाया जाये कि खर्चीली चिकित्सा प्राप्त करने के बाद अधिकतर मरीज़ स्वास्थ्य बीमा की आवश्यकता के प्रति जागरूक हो गये।

बीमा क्षेत्र के उदारीकरण के पश्चात जीवन बीमा कंनियों ने गंभीर बीमारी (सीआई) राइडर्स को प्रारंभ किया और व्यापक स्तर पर उसका विपणन किया। सीआई राइडर्स को पॉलिसीधारकों की ओर से सतर्क प्रतिक्रिया प्राप्त हुई, यद्पि कुछ जीवन बीमा कंपनियां दावा करती हैं कि उनके लगभग 65 प्रतिशत पॉलिसीधारकों ने सीआई राइडर्स को चुना है। अस्पताल व्ह्रों की पूर्ति के लिये सीआई राइडर्स हमेशा अनुकूलतम रास्ता नहीं हैं।

अधिक व्यापक स्वास्थ्य बीमा पॉलिसी के लिये सीआई बीमा एक न्यून लागत विकल्प है। सीआई बीमा चिकित्सा संबंधी व्ययों या दुर्घटनाओं, संक्रामक या तीव्र बीमारियों के कारण किये गये चिकित्सा व्यय को कवर नहीं करती। यह बीमा अधिकतर विशिष्ट जीवनशैली के कारण होने वाली बीमारियों को कवर करती है। सीआई बीमा का प्रभावी उपयोग व्यापक स्वास्थ्य बीमा सुरक्षा की पूरक सुरक्षा के रूप में उपयोग करके किया जा सकता है। दूसरे शब्दों में व्यापक स्वास्थ्य पॉलिसी पर इसे परत के रूप में इस्तेमाल किया जाए। सीआई बीमा के आलोचक आर्थिक जोखिम प्रबंधन के बजाय सीआई पॉलिसी खरीदने की तुलना लॉटरी खेलने से करते हैं।

बीमा कंपनियों को पॉलिसीधारकों को सीआई बीमा की सीमाओं से अवगत कराने तथा इसे केवल पूरक सुरक्षा के रूप में ही उपयोग करने के लिये बढ़ावा देने की आवश्यकता है। उन्हें केवल सीआई सुरक्षा या राइडर्स को सभी चिकित्सा संबंधी व्ययों के लिये रामबाण की तरह प्रचारित नहीं करना चाहिये।

इसके अतिरिक्त, समाज में खुदरा उधार संस्कृति के पनपने से सीआई बीमा को बंधक मुक्ति से जोड़ना उपयुक्त होगा। वर्तमान में बंधक मुक्ति सुरक्षा मुख्यत: जीवन पॉलिसियों पर आवास ऋणों तक ही सीमित है। इसे गंभीर बीमारी के साथ-साथ अन्य बंधकों तक भी विस्तारित करने की आवश्यकता है।

गंभीर बीमारी की विभिन्न बीमा कंपनियों की परिभाषाओं में काफ़ी अंतर भी है। पॉलिसीधारकों की सुरक्षा के दृष्टिकोण से यह आवश्यक है कि आईआरडीए विभिन्न कंपनियों के सभी गंभीर बीमारी उत्पादों की चिकित्सा परिभाषाओं का मानकीकरण करे।

देश में सीआई बीमा के विकास को आगे बढ़ाने में विभिन्न सामाजिक-आर्थिक कारक सहायक सिद्ध होते रहेंगे। विकास के लिये मुख्य कारक निम्नलिखित होंगे -

(1) जीवन की आयु बढ़ाने वाली चिकित्सा तकनीकी की उन्नति और गंभीर बीमारियों (उदाहरण के लिये हृदय रोग) से बचने की बढ़ती संभाव्यता,

(2) गंभीर बीमारी, जो वित्तीय स्थिति और उपार्जन क्षमता पर प्रतिकूल प्रभाव डालते हैं, की अवस्था में होने वाले चिकित्सा व्ययों के भार के प्रति बढ़ती जागरूकता, और

(3) समाज में लोकनिधिक सामाजिक या स्वास्थ्य सुरक्षा तंत्र का अभाव।

इसी प्रकार, अस्पताल राशि लाभ राइडर अस्पताल में दाखिल होने की अवधि में आते हैं। अस्पताल में भर्ती रहने के दौरान प्रति दिन एक दैनिक लाभ राशि का भुगतान किया जाता है। दैनिक लाभ या पॉलिसी लाभ की सीमाएं सामान्यत: छोटी होती हैं और मरीज़ तथा उसके परिवार द्वारा किये जाने वाले फुटकर व्ययों, जो स्वास्थ्य पॉलिसियों के अंतर्गत प्रदान नहीं की जाती, के लिये अच्छी तरह उपयोग में लाई जाती हैं।

व्यापक स्वास्थ्य बीमा

वर्ष 1987 की मेडिक्लेम पॉलिसी को एक व्यापक स्वास्थ्य बीमा पॉलिसी के रूप में निर्दिष्ट किया गया। कुछ अपवादों को छोड़कर यह अस्पताल में भर्ती होने की लगभग सभी स्थितियों को कवर करता है। इस पॉलिसी ने पॉलिसीधारकों को अच्छी सेवाएं प्रदान कीं, फिर भी दावों के निपटारे में विलंब, लाभों की छोटी सीमाएं और राशिविहीन चिकित्सा प्रदान करने के लिये स्वास्थ्य सेवा प्रदाताओं से अनुबंध का अभाव संबंधी समस्याएं हैं। इसमें से कई समस्याएं अब सुलझा ली गई हैं।

फिर भी, जिस रूप में यह पॉलिसी है, वह लाभ और लागत/प्रिमियम के संदर्भ में असंतुलित है। इस असंतुलन के फलस्वरूप उच्च दावे और संयुक्त अनुपात हुये। इसने ग़ैर-जीवन बीमा कंपनियों को निम्न-लागत-उच्च-लाभ मेडिक्लेम पॉलिसी को अग्नि/संपत्ति से संबंधित अधिक लाभप्रद बीमा

प्रीमियम प्राप्त करने के लिये एक उत्प्रेरणा के रूप में उपयोग करने के लिये प्रेरित किया।

यह परस्पर सहायता, जो केवल स्वास्थ्य बीमा करने में रुचि रखने वाली कंपनियों के लिये अलाभकारी है, वैश्विक विशेषज्ञ स्वास्थ्य बीमा कंपनियों, जैसे एटना, बूपा और सिग्ना को भारत में अपनी दुकान खोलने से रोकने में एक महत्वपूर्ण कारक साबित हुई है। इतना ही नहीं, बल्कि इस प्रकार की स्थिति ने वर्तमान व्यवसाइयों को नये उत्पाद विकसित करने के लिये समय और ऊर्जा खर्च करने हेतु संभावना या प्रोत्साहन भी छोड़ दिया है। जो भी कंपनी इस विषम चक्र को तोड़ेगी वह शीघ्र ही हानि में पहुंच जाएगी। हालांकि यह विलक्षण स्थिति स्वास्थ्य बीमा कंपनियों की चिंताओं को घटाती है, लेकिन वास्तव में यह ग्राहकों को हानि पहुंचाती है।

सार्वजनिक क्षेत्र स्वास्थ्य सेवा व्यय के घटने तथा स्वास्थ्य सुरक्षा के अभाव के मद्देनज़र भारत के संदर्भ में स्वास्थ्य बीमा की तीव्रता में वृद्धि सामाजिक-आर्थिक रूप से सराहनीय है। इसलिये ऐसे स्वास्थ्य बीमा उत्पादों की सख्त जरूरत है, जो समाज के विभिन्न खंडों की लाभों और लागत/प्रीमियम दोनों दृष्टि से पूर्ति कर सकें।

हमारी स्वास्थ्य व्यवस्था, जहां अस्पताल शुल्क कक्ष अधिभोग के प्रकार पर निर्भर करता है, यह महत्वपूर्ण है कि प्रीमियमों को उस कक्ष अधिभोग के प्रकार से जोड़ा जाए, जो पॉलिसीधारक अस्पताल में भर्ती होने के दौरान लेना चाहता है। जिन पालिसीधारकों का वर्ग अस्पताल में भर्ती होने के दौरान "टॉप फ्लोर" कक्षों का अधिभोग करना चाहता है, उसे उसके अनुरूप प्रीमियमों का भुगतान करना होगा और जो लोग जेनरल वार्ड में ही "आरामदेह" महसूस करते हैं, वे लोग छोटी राशि का दावा करेंगे, इसलिये उन्हें कम प्रीमियमों का भुगतान करना चाहिये। अधिभोग प्रकार की रोकों के अभाव में वर्तमान मेडिक्लेम पॉलिसी का प्रारूप उच्च उपयोग को बढ़ावा देता है, जिससे अंतत: बीमा कंपनियों पर प्रतिकूल प्रभाव पड़ता है।

उत्पाद का पिटारा

बीमा कंपनियों ने अन्य वित्तीय संस्थानों की भांति विकास करने के लिये प्रयत्न किया और बदलती आवश्यकताओं के अनुसार ग्राहकों को उत्पाद व सेवाएं प्रदान कीं। समाज की मांग का रूपांतरण तथा विकास कर बीमा कंपनियों ने एकदम नये उत्पाद प्रस्तुत कर इस चुनौती का सफलतापूर्वक सामना किया है। अमेरिका में जब साल दर साल बढ़ते दावों ने कर्मचारी स्वास्थ्य सुरक्षा लाभों का निर्वाह करने में नियोक्ताओं के लिये मुश्किल खड़ी कर दी, तब वहां प्रबंधित सुरक्षा का विकास किया गया, जो स्वास्थ्य बीमा क्षेत्र में बीमा उत्पादों के विकास का एक उदाहरण है।

पिछले एक दशक में हमारी स्वास्थ्य सुरक्षा प्रणाली में पर्याप्त बदलाव आया है और उसमें निरंतर विकास हुआ है। चिकित्सा खर्च स्फीति और तेजी से बदलती चिकित्सा तकनीकी ऐसी कार्यनीति का विकास चाहती है, जो समाज के बड़े भाग के लिये चिकित्सा सेवा को पहुंच के अंदर और वहनीय बना सके। वर्तमान समय में ऐसे स्वास्थ्य बीमा उत्पादों की आवश्यकता है, जो वृद्धावस्था स्वास्थ्य सेवा, दीर्घकालीन सुरक्षा, अशक्तता आय, मानसिक देखरेख, अस्पताल योजनाओं आदि की आवश्यकताओं को पूरा कर सके।

वृद्धावस्था स्वास्थ्य देखभाल

वृद्धावस्था स्वास्थ्य देखभाल समाज की एक गंभीर आवश्यकता है और सबसे अधिक एक व्यापक सामाजिक सुरक्षा परिवेश के अभाव में। बीमा कंपनियां प्रतिकूल चयन से बचने के लिये अधिक आयु में नये पॉलिसीधारकों के प्रवेश पर रोक लगाती हैं। सुरक्षा उपलब्ध कराते हुये प्रतिकूल चयन का सामना करने की तकनीकियों को विकसित करने की आवश्यकता है। स्वास्थ्य बीमा राइडर्स के साथ पेंशन उत्पादों का संयुक्तीकरण करने से वृद्धावस्था वित्तीय सुरक्षा व स्वास्थ्य सुरक्षा प्रदान की जा सकती है। इन आवश्यकताओं का परीक्षण प्रायोगिक तौर पर किया जा सकता है। निर्धारित योगदान पेंशन योजना से मिली निर्धारित योगदान स्वास्थ्य योजना इसका एक अच्छा समाधान हो सकती है।

दीर्घकालीन देखभाल (एलटीसी)

एलटीसी बीमा योजनाएं शारीरिक या मानसिक असामर्थ्य की सुरक्षा करती हैं, जो बीमाधारक के दैनिक जीवन की गतिविधियों पर रोक लगाती हैं। यद्यपि आयु किसी भी व्यक्ति की स्वयं की पूर्ण सुरक्षा करने की योग्यता को कम करती है, लेकिन अधिकतर युवा लोगों को अपने दैनिक जीवन के कार्यों के लिये किसी की मदद की आवश्यकता नहीं पड़ती, जबकि कम आयु के ऐसे कई लोगों के उदाहरण हैं, जिन्हें मदद की आवश्यकता पड़ती है। एलटीसी बीमा न सिर्फ़ तेजी से बढ़ती जनसंख्या के लिये प्रासंगिक है, बल्कि यह दुर्घटनाओं या चिकित्सा परिस्थितियों, जैसे कोई गंभीर बीमारी और कमजोर बनाने वाली बीमारी के कारण इसी प्रकार की जोखिमपूर्ण स्थिति का सामना कर रहे मध्य आयु तथा युवा लोगों की वाहक भी है।

अशक्तता आय बीमा बीमाधारक को आय लाभ उपलब्ध कराती है, जबकि शारीरिक या मानसिक अशक्तता उसे कार्य करने के योग्य बनने से रोकती है। शहरी भारत में कई लोग भारी चिकित्सा खर्चों की संभावना से चिंतित हैं और इसलिये वे चिकित्सा खर्च बीमा सुरक्षा चाहते हैं। तथ्य रूप में मरीज़ के परिवार के लिये उसकी मृत्यु से अधिक उसकी अशक्तता का आर्थिक परिणाम अधिक दुष्कर साबित होगा। इसी प्रकार वेतनभोगी जनसंख्या का एक बड़ा तुल्यानुपात अपनी (वेतनभोगी की) संभावित मृत्यु के बाद अपने आश्रितों को आर्थिक संकट के भार से मुक्त करने के लिये ग्रुप और जीवन बीमा खरीद रहा है। फिर भी, बाजार में अशक्तता आय उत्पाद के अभाव में वेतनभोगी जनसंख्या दुर्घटना या बीमारी के कारण अशक्तता होने पर अपनी आय खोने की आशंका से बचने में असमर्थ है। अशक्तता आय बीमा और एलटीसी की आवश्यकता दिन प्रति दिन बढ़ती जा रही है। यह आवश्यकता इसलिये भी अधिक बढ़ रही है, क्योंकि विस्तारित परिवार के विघटन तथा आर्थिक विकास के कारण पारिवारिक समर्थन घटता जा रहा है। संयुक्त परिवार की व्यवस्था, जिसने भारतीय परिवारों को शताब्दियों तक सामाजिक सुरक्षा प्रदान की, तेजी से टूटती जा रही है।

उपसंहार

बदलता डेमोग्राफ़िक खाका और महामारी रोगों के बोझ, स्वास्थ्य सेवा में तकनीकी उन्नति एवं स्वास्थ्य सेवाओं के शुल्क में वृद्धि, सार्वजनिक स्वास्थ्य सेवा विनिधानों के प्रावधानों में सतत गिरावट तथा निजी स्वास्थ्य सेवाओं पर जनसंख्या की बढ़ती निर्भरता के कारण सरकारी नियामकों तथा उपभोक्ता समर्थकों के लिये यह सुनिश्चित करने की समीचीन रूप से आवश्यकता है कि स्वास्थ्य बीमा उत्पादों का एक बड़ा रेंज बाजार में आये।

लेखक दिल्ली के स्वास्थ्य बीमा परामर्शदाता हैं। इनसे ई-मेल : aloke_g@vsnl.net पर संपर्क किया जा सकता है।

Process can Drive Product

- Technology and the Indian Insurer

M. Arunachalam

Here is the second part of the author's overview on Technology and the Indian Insurer. The first part of this series was published in IRDA Journal, May 2004, where the author had discussed some issues involving IT in insurance, the Malhotra Committee's expectations and the business processes that IT supports and enhances like Product Life Cycle Management, Proposal Processing, Illustration and Underwriting. We continue with other processes.

Receipting

Indian insurance companies traditionally receive premium/loan repayments by way of cash/ cheque. Such a method of collection is expensive and inconvenient to the policyholder. Indian insurers should prefer other modes of premium payments rather than walk-ins by policyholder and agents. With advancement of payment technology, there are different mediums of premium payment.

The options to pay premium/loans are:

1. At the branch – Cash, Cheque, Credit/ Debit cards
2. By post – Money Order, and Cheque
3. Through Credit/ Debit card over the Internet
4. IVR – Through Credit/ Debit card
5. Auto-Debit – Debiting from the bank account, on the lists of policies sent electronically as and when due. Pre Authorised Cheque (PAC) is a preferred method of payment in US.
6. Salary Deduction – Facilitating deduction from salary of employee by employer. This, together with payment from provided fund, is in wide use and it is discussed separately in view of its importance and complexity in India.
7. Credit Card debits – authorizing the credit card issuer to pay premiums.

The last three are very cost effective modes of premium transactions, as receipts need not be printed for every transaction and hundreds of policies can be handled in a group. The preferred methods carry with them two significant advantages:

1. The cost of transaction in all these is significantly less as compared to branch collection, and in addition it ensures convenience to customers, and
2. In most cases, such methods ensure high persistency.

A step further in premium collection, as was seen in a US company, is billing for all family members together but payments can be accepted for the family as billed or for any desired individual component The insurer offers discount for such payment methods based on the total bill amount paid. They are planning to include non-life premium payments thereby allowing 'Single View of All Customers in a Family.'

> More convenient payment methods are required in cities where people do not find time to visit offices during cash hours and rural areas where there are currently not many facilities.

In the US, many companies employ the Centralised Payment Processing System (CCPS) and bills with Bar Codes received by post get automatically receipted, payments applied appropriately, and receipts posted promptly. This encourages people to send cheques together with bills by post.

One other customer-oriented facility in the US (not in vogue in India) is to allow premium payments in modal installments for non-life policies also, particularly in property and engineering risks. The very same reminders and default notices as in life policies are provided.

Thanks to the front office system for cashiering in LIC, the customer service in India has improved and long queues have become a thing of the past. Another remarkable feature in LIC is that premium payments can be made irrespective of servicing branch in any office and it is a boon for people with multiple policies taken from different branches. Corporation bank inaugurated payment of LIC's premium bills through ATMs and such facilities are bound to come in in a big way shortly.

In addition to the above, facility to pay premiums and loan repayments by combination of Cash, Cheque, Credit card etc to any branch of the insurance company in a single receipt for singe/multiple policies will be a welcome feature. In India, banks have installed drop boxes at convenient locations for customers to drop cheques towards credit card bills payment.

At any rate, more convenient payment methods are definitely required in cities where people do not find time to visit offices during cash hours and rural areas where there are currently not many facilities as of now. For all renewals, even for non-life policies (such as Motor and Householders'), the policyholder must be able to pay premium through the Internet or through IVR without having to call at the insurer's office.

Salary Savings Scheme (SSS)

This scheme of payment deserves special mention. In earlier years, SSS was the most preferred among salaried class of policyholders. In some branches of industrial areas such as steel and mine towns, or where business is procured at the worksite, a high proportion (sometimes even 90 per cent) of policies are issued under this scheme.

The policyholder perceives the benefit of this scheme as painless (automatic) payment of premium. For the insurer, if it is well administered, it prevents lapses.

Despite these significant benefits, servicing of salary savings policies is still troubling all – insurer, employers, policyholders, employees, and agents.

Premium status is not transparent to customers. IVR and Kiosk excludes paid-to-date for SSS policies. Agents have grievance for delay/omission in commission. Front office SSS administration, it is stated, has improved the working. Against this situation, the following example deserves a mention.

A major life insurer was maintaining salary deduction policies for big establishments like the defence forces. It had a centralised accounting section with twenty analysts (the designation given to them). Where the premium is paid 'as billed', the accounting is done by two staff at the entry point called 'jet' processing (like express or green channel that we have). The rest goes to the 'analysts.' The system provides very interesting features, and some of these as recollected are:

- Billing for higher frequencies like fortnightly or weekly or lower frequencies like quarterly, although it is usually monthly.
- Automatic exclusion of billing for teachers on vacation as they are not paid for this period.
- Billing, not only of current premium, but also arrears of premium and loan repayments if the policyholder has opted for it.
- Responding to different payment methods: return of hard copy bill, electronic bill, floppy, tapes, or excel files and variations list based on previous payment, and so on.
- Automated routing of bills, to employers, provident fund trustees, or servicing agents, (one agent is designated for every paying institution and he is the liaison point for smooth working).
- Extension of the system to deduction from provident fund trustees, which are annual.
- Allowing rule-based rebates to employers for the services rendered, tolerance in cash shortage either for the paying unit as a whole or at policy level individually.
- Automatic application of dividends (equivalent to policy bonus in India) if opted for.
- Accumulation of remittances if received piecemeal (say on weekly payments) for application on the due date.
- Automatic application of advance premium payments when received (reflected duly in the bill).
- Accounting of excess payments received, and holding in suspense at policy level, customer level or unit level triggering action on day-to-day basis with the help of online system.
- Recognition of refunds, automated cheque writing to the employer, employer or a third person if required.
- Daily update policy premiums and other transactions, generating lapse or default notices for individuals or units as a whole if they have not sent the remittance.
- Ledger is maintained on monthly basis and that acts as a 'court of appeal' in case of any dispute, but the beauty was that rarely any complaint was seen.

The lesson is that if there is a well-designed, user-friendly system with complete controls, complexity to any extent is amenable to handling.

- Every day balance sheet for all payments received and applied, tallied to every cent.

During the system reengineering, it is amazing to see the system that was built in (even three decades back) with user-friendly, analytical features, and many remarkable controls that the particular process requires. No error can easily creep in, and all exceptions are tracked for quick resolution. The lesson is that if there is a well-designed, user-friendly system with complete controls, complexity to any extent is amenable to handling. People in the process do not experience any stress but enjoy working. A step further is to publish the billing information on the Internet, which can be updated by employer with remittance details, and this was being deliberated.

To a large extent, a system on the above lines should meet the requirement of group life, health and annuity also.

Claims

Improving claims processing also has strategic value and builds brand image. Modern claims management is linked to the customer orientated and the overall business culture. Active case management, transparency, precision, thoroughness and efficiency characterise claims handling.

By implementing the right IT system, insurers derive multiple advantages: reduced cycle time ensuring lower costs and happier customers, happy workforce, and in addition, benefits by way of the wealth of information and intelligence built into decision support systems. Seven-eighths of claims received by Blue Cross Blue Shield, Michigan, from physician offices and hospitals are sent and processed electronically. Almost all of prescription drug claims are processed electronically.

To quote an example of a life insurer in US, a claimant intimates the death through a customer service representative or agent who in turn reports the claim through a Web-based application. The claim system pulls the policy data (even for multiple policies of the same life) including customers and beneficiaries' information (surprisingly from different databases).

The reported claim undergoes an initial analysis, and claim amount is calculated in the system. It checks statuses such as 'contestability' period. The forms based on product and claim scenario are generated and sent electronically to the agent for completion by claimant. When the completed forms are received physically, claims are validated once again with reference to business and state rules (which vary from state to state). If additional information is needed, letters are printed automatically.

Approval for claim is routed at appropriate levels. The payment options include cheque payment (automated printing), electronic fund transfer, bank wire, applying towards other products like settlement options and mutual funds or third parties. The whole process is controlled by a workflow mechanism, and a single process settles the claims on different policies on the same life. Claims

data automatically flows to actuarial system for appropriate analysis. E-mail is extensively used to expedite processing and importantly agents are kept in the communication channel. To be of help to the claimant, an agent (selling or servicing agent or anyone else) is invariably earmarked. The moment the claim is added, all actions to the policy are frozen. Claims processing efficiency has increased considerably due to workflow based automated processing, claim kit through electronic mode, sending automated emails and clubbing all policies in a single process. The whole cost of processing is substantially reduced, with incidental benefits like error reduction and improved claim tracking. There has been positive impact on the workforce who longer needed routing of paper files and manual scrutiny.

In a Malaysian company for automobile insurance, the parties to the claim (insurer, claimant, workshop, adjuster and possibly lawyers) work in a collaborative mode, to reduce the claim processing time drastically. For example, the insurers through the Internet, see online the workshop estimates. The report of the adjuster is sent to the insurer through the net. The claim adjustment costs are significantly brought down through this medium.

Not all adjusters can investigate every type of claim. The profile of the adjuster is important since the claim adjustment is a complex process. The system should smartly spot out an adjuster for the claim depending on the line of claim (Motor, Fire, Marine etc). It is advisable that the system builds the adjuster's profile and experience based on the claim settlement.

It may take sometime for insurers in India to reach this stage but right efforts are required now to build the basic system. Automated claims processing can well fit in with corporate clients initially. At any rate, a well-defined claim system will aid in collaborative processing.

As in the example quoted above, it is very important that IT systems keeps agents as part of the claim process and is part of all communications.

Agency Administration and Compensation

Agents are seen in insurance companies at least equal to policyholders. They are both internal customers and external customers. The traditional sales channel continues to be dominant and accounts for the largest share of the business. In life insurance, most CEOs rank distribution management as their dominant challenge. In life insurance, different practices are followed in different countries. Some companies pay commission on annualised premium, some allow deduction of commission from premiums and so on. Whatever method is in vogue, it needs to be administered well. Importantly, commission needs to be omission/error free with the bill being generated in time irrespective of whether the policies are serviced locally or at other branches, which is the case in a good number of SSS policies. Multiple commission bills are generated especially for policies serviced in other divisions. There is scope to reduce duplication of bills using IT appropriately.

The commission pay structure in India is not on par with global practices and will evolve to meet those practices. IT systems should meet such imperative changes.

Payment of commission has to be fair, efficient and prompt. The IT systems should be flexible enough to meet the changing commission structure. It is worth mentioning that a leading life insurer in the US decided to totally change its compensation structure (primary and secondary) from a cut off date, with a transition arrangement for the existing policies and, surprisingly, technology was not an impediment for its decision. The commission pay structure in India is not on par with global practices and will evolve to meet those practices. IT systems should be such that it meets such imperative changes.

In the US, one life company generates a comprehensive commission and business statement for the specified period (usually weekly), which gives details of commission (first, first year and renewal commission, and service commission), lists the policies introduced and exited during the month, persistency ratio for 104 weeks (to which the commission rate itself is dynamically related), advance drawn, tax deducted etc. Commission is settled mostly through bank credits, say every fortnight or month. The commission is for the entire insurance company and that includes commission based on different levels in the hierarchy of distribution (including its managers) for both life and general insurance businesses. The company has ten different units taken over and is in the process of standardising compensation settlement through a single process.

The secondary compensation of the above company includes overriding commission, deferred compensation, persistency bonus, asset growth bonus, eligibility for sales meets and awards in sales contests. The whole system is interfaced with production data, agency management system, and accounting system. Such complex compensation management cannot be handled without an efficient IT system.

Besides commissions, there are others streams within agency which technology has to effectively address. It is Agency Human Resource (HR): promotion, demotion, termination, and reinstatement etc of the agents besides their terminal benefits like gratuity. The system should in addition give continuous guidance to agents in achieving the best performance in terms of new business brought in and conservation of existing policies.

Besides the above, the agents in India would expect lead generation and management with the help of technology based on the customer database and external data provided by insurer. Insurance companies in advanced countries have provided software to agents for customer management as that happens in the electronic version of 'One Card System' for building financial services clientele, and other field technology software for them to make clear and professional presentations on their laptops to aid their selling in complex situations.

Persistency

Persistency management is a priority area, as important as new business acquisition itself. There are statutory

returns for lapse statistics. But persistency is not talked about with the importance that it deserves.

Tracking persistency for 12, 24, 36 months and analysing in terms of region, office, channel, pay method and product needs to be a continuous process. Many US companies provide serious attention to this aspect and take proactive steps as around 60 per cent of the products there are term insurance. In India, with the dominant portion (at least 80 per cent) being of investment (permanent/endowment) plans, both policyholders and insurers lose heavily particularly in early lapses.

Here is how technology helps in controlling lapses: profile or need-based selling (with illustrations, discussed), improving payment methods (as discussed), generating default and lapse notices in time, keeping the agents communicated on defaults or possible lapses, user-friendly restoration, special campaign, regular communication to field, a continuous monitoring of lapses (as above), and linkage of agents compensation to persistency.

It is important that default and lapse intimations are processed for SSS policies also. Further, effective actions such as automatic premium loans in terms of non-forfeiture actions are important. Only an effective IT system (not any manually operated scheme) can perform these series of steps. Two things noticed in a company in the US are worth mentioning:

- IT system provides a rolling persistency of every agent based on 104-weeks time period. The commission rate itself (apart from other factors such as products and policy years elapsed) is linked to persistency rate.
- If any agent exits, the IT system provides a list of policies under his/her account which are reviewed and re-allotted to another agent (especially newcomers) with twin objectives: customers get continued attention and the newly appointed sales agents get service compensation, ultimately ensuring that no policy is orphaned leading to its lapse for want of service.

New insurers have a higher responsibility in persistency management, as their cost of acquiring / building the field force and acquiring business is relatively high.

IT Support for Modern Products

In the 1980s, the US insurance market introduced a number of new life insurance products such as interest sensitive insurance, unbundled (universal life) and unit linked (universal variable insurance/ variable annuity). All these complex products would not have come into existence and been serviced but for an appropriate IT system. For example:

- The administration of universal insurance requires crediting policy payments less expenses, debiting mortality charges based on net amount at risk calculated dynamically, crediting of interest earnings, maintaining units account, and generating a very sophisticated annual statement with projections for 10 to 15 years to come. The product provides flexible premium and coverage options under Plan A or B (Option 1 or 2), and death benefits vary with these options. The policy continues even if premiums are not paid as long as its cash value can sustain.
- The administration of variable products involves options of several investment strategies (even over 40 in one company), and selection of any one or more amongst them in different combinations, complying with security exchange commission rules, and allocation or reallocation of fund on demand or its automatic rebalancing on a variety of predefined options among strategies are all complex processes which definitely require high-end IT systems.

> Persistency management is a priority area, as important as new business acquisition itself. But it is not talked about with the importance that it deserves.

The insurance company at the close of the working day collects investment value for their thousands of investment accounts (over the Internet, fax, phone, mail and all means) and calculates the net asset value for each of the strategies and the individual accounts. While there is no guarantee of return, death benefits are guaranteed to the extent of investments made for which mortality charges are appropriately collected. The customised options effectively satisfy what he wants. A feature-rich system alone can manage the separate accounts (the term used in the US) as distinct from general accounts, which the insurers usually maintain.

Before such products will most probably be introduced in a big way in India, there is an imperative need to install software solutions that will meet these functions.

Service Commitment Benchmarks

It is important to publish SCB regularly to substantiate customer service. Any customer service has to be measured quantitatively and performance reviewed against the metrics. For example

- Maximum time (in working days) to issue a policy if all the conditions have been met
- Maximum time (in working days) to pay claim on receipt of all documents
- Maximum time to inform policyholders about change in policy conditions like lapses, non-forfeiture withdrawal etc.

The tools should transparently and rightly capture these metrics without manual compilation on every touch point and then a report is generated for the same indicating deviation from SCB. This can be emailed to relevant department managers or can be published to stakeholders. Correctly designed dashboards can indicate a real time operational efficiency, and will help companies stay competitive.

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

Report Card: GENERAL

Year begins with 12% accretion

G.V. Rao

Performance in April 2004

April, the first month of the new financial year, is considered quite significant for measuring premium growth, as a large number of corporates renew their annual insurance covers with revision in values and seek additional covers. About 12 to 15 per cent of the total business of the year is usually completed in April.

The premium performance of the non-life industry in April 2004, at the beginning of the new financial year 2004-2005, shows up a few characteristics that deserve special notice. And if this performance is benchmarked against a few performance indicators of the fiscal that has just ended (2003 - 2004) it throws up a few interesting points to ponder.

The performance in the fiscal 2003-2004 showed that the private sector insurers had recorded an average premium growth rate of 70 per cent, the public sector insurers seven per cent and the non-life industry as a whole a growth rate of 13 per cent. The public players' market share was 86 per cent down from about 90 per cent in the previous year. Keeping in mind these broad indicators, how has the new fiscal 2004-2005 unfolded in April 2004 for the two dominant sectors and the various companies?

The premium growth rate for the industry for April 2004 is 12 per cent (13 per cent in the year 2003-04). The private players growth rate is 37 per cent (70 per cent), the public players 7 per cent (seven per cent) and the market share of public players at the end of the month of April 2004 is 80 per cent (86 per cent). The growth rate of the private sector companies has come down significantly from 70 per cent to 37 per cent. The market share of public sector companies has slid by more than six per cent and three out of the four public sector companies are showing low single digit growth rates for the second year in succession.

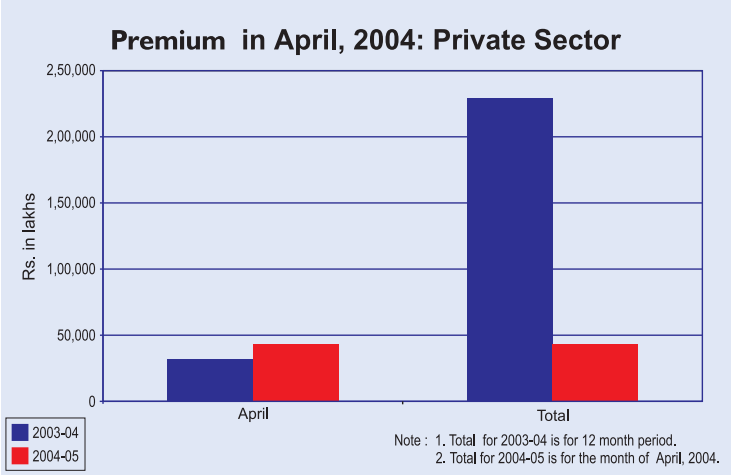
The premium accretion in April 2004 was Rs. 225 crores (12 per cent growth) of which the private players have contributed Rs. 115 crores (37 per cent growth) and the public players Rs. 110 crores (seven per cent growth).

Gross Premium Underwritten – April 2004

(Rs. in lakhs)

INSURER	APRIL, 2004	APRIL, 2003	MARKET SHARE	GROWTH % YEAR ON YEAR
Royal Sundaram*	3,701.29	3,088.74	1.76	19.83
Tata AIG	7,432.89	6,727.40	3.53	10.49
Reliance General	2,197.26	1,916.23	1.04	14.67
IFFCO-Tokio	6,619.64	5,571.22	3.14	18.82
ICICI Lombard	11,451.76	7,528.78	5.44	52.11
Bajaj Allianz	8,086.06	5,359.85	3.84	50.86
HDFC Chubb	1,253.18	283.73	0.60	341.67
Cholamandalam	2,294.25	1,053.44	1.09	117.79
New India*	48,410.00	46,020.00	22.99	5.19
National*	41,101.00	34,161.00	19.52	20.32
United India*	37,771.00	37,293.00	17.94	1.28
Oriental*	37,101.00	36,421.00	17.62	1.87
ECGC	3,158.55	2,563.01	1.50	23.24
PRIVATE TOTAL	43,036.33	31,529.39	20.44	36.50
PUBLIC TOTAL	1,67,541.55	1,56,458.01	79.56	7.08
GRAND TOTAL	2,10,577.88	1,87,987.40	100.00	12.02

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



April and the private sector

The April premium performance shows that the private sector companies that are used to recording growth rates of 70 per cent are suddenly finding the going tough; their growth rate in April 2004 is just 37 per cent. Even in March 2004 their growth rate hovered around 50 per cent. Is the downward trend in the growth rate a reflection of the market discipline they have decided to implement? Or are they finding it difficult to win more and more corporate accounts that want to stay loyal to public sector companies? Should they now start looking for creation of new markets instead of merely offering competition?

Excepting for ICICI Lombard (52 per cent growth) and Bajaj Allianz (51 per cent) the four other major private companies have recorded growth rates less than 20 per cent. HDFC Chubb and Cholamandalam have done very well. Tata AIG that had shown a loss of Rs. 10 crore in premium in the month of March 2004 has recorded a growth of Rs. seven crores(10 per cent growth) in April 2004.

These lower growth rates if they persist could bring the industry averages further down. With the viability of their operations ensured through their profit making in 2003-2004, as some companies have announced in the press, they are now better poised to widen the market.

April and the public sector

The public sector companies have revised their data for April 2003. It is not clear why. United India and Oriental have shown growth rates of less than two per cent each in April 2004 that are lower than their previous year's average of three per cent. New India has come out with a growth rate of five per cent up from three per cent of the average of last year. The overall growth rate of seven per cent in April 2004 as against the average of seven per cent for the last year shows that they are not yet able to cash in on the excellent performance of the public sector units in the national economy. But for National Insurance, which continues to outperform the market with their growth rate of 20 per cent, the performance of public players would have been much lower. That for two years in succession, three out of four public players are finding it tough to improve growth trends perhaps could only be explained when their Annual Statements are published giving departmental premium growths.

Market shares

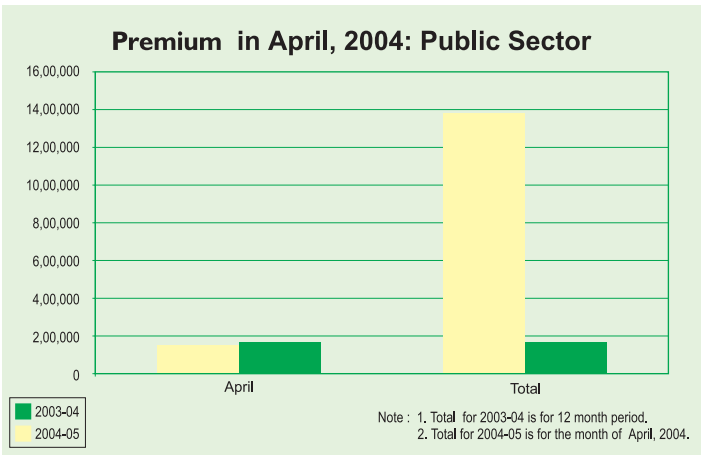
Yet again, it is the changing market shares that show the public players in a different light. Their earlier market share of 86 per cent at the end of March 2004 has dropped to less than 80 per cent in April 2004.

A final comment

The performance of the Non-life industry in April 2004 has not been an enthusiastic one. The growth rate of 20 per cent seen for the month of March 2004 has slid to 12 per cent in April. The private sector at 37 per cent growth rate is finding the going tough whatever the reasons be for it. It is not likely that in future they will continue to produce growth rates of 70 per cent as they used to. The public players have begun with a growth rate of seven per cent aided mainly by the performance of National Insurance. The market share of public players down to less than 80 per cent is likely to come under further threat in the near future.

With private players losing their initial thrust, it is a matter of some concern that the future growth rates in the market are going to be more difficult to achieve on sheer momentum alone, unless focused efforts are made to explore and create new markets and new customers. Perhaps the playing field is getting more and more levelled. Now it is up to the companies to show their expertise and skills.

The author is retired CMD, The Oriental Insurance Company Ltd.



RBI idea for dedicated state pension fund

The Reserve Bank of India (RBI), it is reported, has proposed a dedicated pension fund, to be created through a levy on existing employees, for meeting the huge pension burden of state governments. In its latest report on state finances, the central bank has said this would at least partially meet the pension burden of the existing employees and pensioners.

Besides levying a cess, a portion of the increased salary and dearness allowance could be set aside to create the fund. A Reserve Bank working group to study the pension liabilities of the state governments has also recommended reduction in the leave encashment period in a phased manner.

It has also suggested that the savings should be kept outside the states' consolidated fund and the public account.

Besides pension liability, RBI has voiced concerns over deteriorating state finances on account of rising interest payments and bloated guarantees, some of which are not fully reflected in states' budgets. However, the ratio of states' own tax revenue to GDP showed signs of improvement in the recent years — from 5.6 per cent in 2001-02 to 5.9 per cent in 2002-03. It is budgeted at six per cent in 2003-04, according to the Reserve Bank report.

Pension liabilities of states account for about 10 per cent of revenue receipts, against below three per cent in the '80s. Recognising the need for rule-based fiscal reform process, the Centre and several states have enacted fiscal responsibility legislation. The central bank had constituted a committee to frame a model fiscal responsibility legislation at the state level and the report is being finalised.

RBI has said it is imperative that states augment their tax receipts through better tax administration, improved tax compliance and rationalisation of the tax structure. It also said restructuring of public enterprises is another critical area for improving the health of state finances.

In the context of the fiscal challenges faced by the states, the issue of transparency in government budgetary operations assumes critical significance for sound fiscal management and attainment of macroeconomic balance. Besides, it has expressed concern over the declining developmental and social sector expenditure by states.

LIC STAFF TO IIMs

To face competition from private insurers, the Life Insurance Corporation of India (LIC) is reportedly planning to put its officials through courses at the Indian Institutes of Management (IIMs).

LIC Managing Director Mr. R.N. Bharadwaj has been quoted saying that LIC staff would be trained in investment management, financial management , marketing and human resources management. Besides this, some executives would be trained or deputed abroad, he said.

Bharadwaj said the arrival private insurers meant competition, but LIC still had a big lead over them.

"Of the total life insurance business in India, LIC has 95 per cent," he said. "The field is still wide open, for LIC has covered only 22 per cent of the total market of 340 million potential clients."

The challenge for LIC, he said, was to adapt its set-up to the customer of today, who is more knowledgeable and discerning, and therefore, more demanding.

He said LIC needed to equip its agents with technical skills that would match their counterparts from private insurers. Also on the cards, he said, was a system to alert customers of their premium due dates by short messaging service (SMS).

Bharadwaj ruled out LIC setting up its own bank like many private insurers. "We are fine with our 27 per cent equity stake in Corporation Bank," he said.

ISRAELI FIRM TO SELL V-SATS TO ITC FOR E-CHOUPAL

Israeli firm, Gilat Satellite Networks Ltd, has announced it has signed a multi-million dollar contract with ITC Ltd. to supply VSATs for the company's expanding Internet project, E-Choupal, now reaching over two million farmers in six states.

As per the agreement, Gilat will be supplying its Skystar 360E VSATs to the Indian company as it expands its operations to cover 11 more staes. The Israeli firm has already supplied over 1,500 VSATs during the past 12 months, primarily for ITC's E-Choupal project.

Part of the implementation of the E-Choupal network is being carried out by Gilat's long-time customer and system integrator, HCL Comnet Ltd. 'The enthusiastic response from farmers has encouraged us to plan for the extension of the E-Choupal initiative to 11 other states across India over the next few years.

'There are plans to channelise services related to micro-credit, insurance, health and education through the same E-Choupal infrastructure,' a company release quoted ITC's International Business Division CEO, Siva Kumar, as saying.

ITC E-CHOUPAL WINS WORLD BUSINESS AWARD

ITC's unique Internet-based rural project "e-choupal" has won the inaugural "World Business Award" instituted in support of the United Nation's Millennium development goals. This is the first worldwide business award to recognise the significant role business can play in the implementation of the UN's targets for reducing poverty around the world by 2015. The award has been instituted jointly by the International Chamber of Commerce (ICC), the HRH Prince of Wales International Business Leader's Forum (IBLF) and the United Nations Development Program (UNDP) recognising companies the world over, who have made significant efforts to create sustainable livelihood opportunities and enduring wealth in developing countries. The award would be presented at the ICC World Congress on June 8, 2004 in Marrakesh.

Commenting on the achievement, Mr. S. Sivakumar, Chief Executive, ITC' Agri-business, said, "ITC's e-choupal has demonstrated that it is possible to closely dovetail the objective of business enterprises to create shareholder value with the superordinate goal of creating value for the larger society.

Indeed, only such convergence can enable development efforts to be scaled up significantly," ITC's e-choupal is aimed at making the Indian farmer informed through the service of providing customised knowledge in the native language about product quality, production methods and markets. The e-choupals are already benefiting over 2.4 million farmers with over 4,100 e-choupal installations covering 21,000 villages in six states.

The company has set a target of covering 1,00,000 villages, representing one sixth of rural India and create over 10 million e-farmers over the next decade.

BIMA NIVESH

The Life Insurance Corporation of India is reviving Bima Nivesh, it is reported.

Called the Bima Nivesh 2004 (Table No. 166), LIC will introduce the revised version of Bima Nivesh as an investment-oriented insurance plan.

The plan would be available for fixed term of five and 10 years under the single-premium mode of payment. The minimum sum assured offered is Rs 25,000, an LIC release said.

The guaranteed additions at the rate of Rs 40 per Rs 1,000 per annum would be payable under the five-year plan and Rs 45 per Rs 1,000 per annum under the 10-year plan, it said. There is no upper limit for sum assured, LIC added.

Depending upon the corporation's experience, loyalty additions may also be payable on maturity. In case of death, prior to the date of maturity, full basic sum assured and an additional term assurance benefit (in case term rider option is exercised) along with guaranteed additions will also be paid.

The plan is ideally suited for those who have no regular but good periodical income. The liquidity facility includes loan and surrender value on expiry of one-year period.

Tata Consultancy Services buys Phoenix arm

Tata Consultancy Services (TCS) has announced it will acquire Phoenix Global Solutions, a unit of The Phoenix Companies Inc. to tap its expertise in the insurance sector, it is reported.

Bangalore-based Phoenix Global Solutions, set up in 1996, provides information technology, customer care support and business process outsourcing services to the insurance industry.

"This acquisition is in line with a focus to consolidate on the strengths developed by TCS over a period of time in the financial industry," TCS Chief Executive S. Ramadorai said in a statement.

The company did not indicate the value of the transaction, TCS's fourth acquisition in less than three years.

Unlisted TCS, a division of Tata Sons Ltd, the holding company of one of India's largest industrial conglomerates, is widely expected to float on the Bombay stock market soon.

NEW HEAD FOR HCL TECHNOLOGIES' INSURANCE PRACTICE

HCL Technologies Ltd , (HCLT) a leading provider of IT - solutions, announced the appointment of Mr. Stuart Drew as Director (Europe) Global Insurance Practice. Mr. Drew will be responsible for managing HCL Technologies' insurance operations in the United Kingdom and Continental Europe, operating out of London.

Mr. Drew has over 25 years of IT professional services experience including the past 14 years focusing on Insurance and Financial Services. He joins HCLT from Deloitte Consulting where he was Senior Director - Financial Services, as well as a non-Executive Director for Sherwood International.

HCLT's Global Insurance Practice offers business solutions to global insurers operating in the Life & Annuities/Pensions, Property & Casualty/ General, Health and Reinsurance segments. HCLT's Global Insurance Practice works with over 30 insurance clients worldwide, with operations in the USA, UK, India, and Asia Pacific.

As of 31 March 2004, HCL Technologies Limited, along with its subsidiaries, had 14,783 employees, with operations spanning 26 locations in 14 countries.

KOREA INSURANCE CANCELLATIONS RISING

Amid the prolonged economic slowdown and rising default rate, a growing number of Korean people are cancelling their insurance policies, as they did after the financial crisis in 1997.

The number of insurance policies cancelled, including automatic invalidity, topped 8.5 million in the 2003 fiscal year, which ended last March, the highest in five years since it peaked at 9.49 million in the fiscal year 1998.

The figure for the 2003 fiscal year, which ended in March 2004, grew about 40 per cent from 5.98 million cases in the 2002 fiscal year, according to the Korea Life Insurance Association (KLIA).

"There is no room for many households and individuals to pay premiums while they are struggling to pay their credit card bills," said an official of the Financial Supervisory Service (FSS).

He said most local life insurers, including Samsung Life, are suffering from high cancellation ratios in "guarantee-type" insurance contracts, particularly, rather than "savings-type" insurances.

The number of cancelled insurance policies stood at 4.99 million in the 1996 fiscal year and it recorded below 6 million in the fiscal years of 2000, 2001 and 2002, respectively, the KLIA reported.

Singapore's life premiums up 48% in first quarter

The Life Insurance Association (LIA) said total new business premiums in the first quarter to March rose 48 per cent year-on-year to S$264 million from S$178 million due to a strong global recovery and better investment climate.

LIA expects business sales this year to rise as long as the economy continues to improve.

"If the economy continues in its current buoyancy, we can expect an upward trend in terms of business sales for the industry this year. Investors' confidence has returned and we should see growth in all segments of the life insurance industry," LIA said in a statement.

Kidnap insurance for rich Chinese

Kidnap policies are the latest product to hit the Chinese insurance market, reflecting rising crime and a rapidly growing army of yuan millionaires, state media in China has reported.

The product from AIU Insurance, an arm of US-based American International Group, covers ransom money as well as expenses such as lost salary, medical costs and psychological counselling, the China Business Weekly said.

'We believe there is a big market for this product,' a spokesman for AIU's branch in southern Guangzhou city told the paper.

There are three million people worth at least one million yuan (S$208,000) in mainland China, and a top concern for many of them is personal security, according to previous reports in the local media. They are under threat not just from local criminals, but also foreign gangs, as an increasing number are going overseas on business trips.

Lloyd's Wins Against Silverstein; No Swiss Re Verdict

A Lloyd's of London syndicate and seven other insurers including Chubb Corp. prevailed over World Trade Center leaseholder Larry Silverstein in a series of verdicts that may leave the developer short of what he needs to rebuild at Ground Zero.

U.S. District Judge Michael Mukasey ordered jurors to resume deliberations regarding Swiss Reinsurance Co. after they reported themselves deadlocked on a verdict for the Zurich-based insurer, holder of $877.5 million, or about a quarter of Silverstein's $3.55 billion policy.

An 11-member jury concluded after seven days of deliberations that the insurance offered by Lloyds and seven other insurers — holders of about $1.1 billion of Silverstein's $3.55 billion policy — was governed by a form that defines the September 11 attacks by two hijacked jets as a single insurable loss.

Silverstein had said the binding document was a different form, which doesn't define a loss occurrence and might have entitled the 72-year-old developer to almost double the policy's face amount by counting the attacks as two events.

The jury found that three of the insurers in the trial — Royal & Sun Alliance Insurance Group Plc, Hartford Financial Services Group's Twin City Fire Insurance Co. and Zurich Financial Services AG, representing about $176 million of coverage — didn't offer policies based on the form defining the attacks as one loss.

The jury's inability so far to reach a verdict regarding Swiss Re may increase the chances of a settlement between the biggest trade center insurer and Silverstein, said David Metzler, who litigates insurance coverage cases for Cowles & Thompson in Dallas. Mediation is also a possibility, he said.

The proceeds will fall short of Silverstein's $7.5 billion estimated construction cost for the entire project, meaning he will either have to borrow the rest or renegotiate his 99-year lease with the Port Authority of New York and New Jersey, owners of the 16-acre site.

CHINA RELAXES INSURANCE STAKE CEILING

China Insurance Regulatory Commission has doubled the maximum stake a single investor can own in an insurance company to 20 per cent to attract more capital and encourage the industry to expand.

The regulator also eased the amount of capital insurance companies have to add to set up new branches.

An insurer with the minimum 200 million yuan in registered capital will need to increase capital by 20 million yuan when opening a branch in a new province, reduced from 50 million yuan. The ceiling on foreign ownership in a domestic insurance company remains at 25 per cent under the new rules.

The government will lift restrictions on where overseas insurers can operate at the end of the year to meet pledges made on joining the World Trade Organisation in 2001, the regulator's website said.

Insurance companies in China had more than one trillion yuan in combined assets as of the end of April, the regulator said. Assets of overseas and joint-venture insurers totalled 23.5 billion yuan.

The new rules do not give foreign investors management control over these Chinese insurance companies.

China last year raised the maximum stake overseas investors can own in its banks from 15 per cent to 20 per cent.

Effective Risk Management Begins at Board Level

Lord Levene, Chairman of Lloyd's, the world's leading specialist insurance market, addressed U.S. business leaders about new global risks that threaten corporations including, but not limited to, business interruption costs, corporate fraud and increased liability claims.

He said that at a time when America is still managing the impact of major corporate collapses and terrorist attacks, it is critical that business leaders understand that we have entered a new era of risk.

Lord Levene called for business leaders to:

* Raise risk awareness to the boardroom; and
* Respond actively to the changing risk environment, including risks associated with business interruption and intellectual property.

He also told insurance leaders that the insurance industry must return to stability for the benefit of insurance buyers.

"Looking ahead ten 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," Lord Levene said. "Effective, integrated strategies for dealing with tomorrow's risks require a change in culture at board level now."

Agency in your Palm!

Application service provider (ASP) eAgency is taking its business outside the PC and onto Blackberry-powered mobile devices, after a two-month development effort with Sun Microsystems and Research in Motion .

The Newport Beach, California-based ASP caters to independent insurance agents, most of whom work from their home or small offices with no access to IT support.

Called Nice Office Wireless, the application provides services including customer relationship management (CRM), claims status information and insurance form services over a BlackBerry-powered device. The ASP said its market includes approximately 2.5 million independent insurance agents in the U.S.

Agents face serious problems in getting data and quotes from their company and spend a lot of time on their mobiles trying to access it from someone in their company.

Now, instead of going online and downloading forms from the eAgency Web site, agents can call up the information from their mobile devices, and then either e-mail or fax the form to the customer. Customer information can be called up immediately, as can underwriting or commission status.

Nice Office is the kind of application that Research in Motion (RIM), manufacturer of the BlackBerry device and developer of the software, said is needed to meet demands for industry-specific sectors.

Tax and Life Insurance Companies

G. Saikumar

Introduction

Taxation of life insurance companies is distinct from taxation of other commercial entities. Life insurance business consists of issuance of life insurance policies and granting annuity on human life. The policies are issued for a long term period ranging from five to 25 years or even more and profit can be estimated only when all the contracts as a batch are completed. Therefore unlike other commercial organisations, the concept of "Profit" cannot be ascertained in life insurance companies with certainty for a particular year.

Issues like taxation of pension funds/gratuity funds or special businesses like capital redemption and annuity certain, service tax and other life insurance business will arise. In this issue, let us deal with taxation life insurance companies and different approaches followed for the same.

Methods of Taxation of Life Insurance Companies :

Internationally, the following two methods of taxation of life insurance companies are practiced

- *Investment Income and Expenses method and*
- *Valuation Surplus Method*

Investment Income less Expense Method :

Insurer collects premiums and incurs claims and expenses and balance of the amount (referred as "Fund") is invested. The "Income" of the insurer under this method of taxation is defined as the income generated through the investment of this fund. This is similar to taxation of an investment company.

Income generally includes interest income from debt securities, dividend income from equity and preference shares, rents from properties and realised gains through sale of investments. Some of the investment incomes (like Dividends) are exempt from tax at the hands of the recipients. Gains on sale of investments are treated as capital gains. Therefore, total investment income should be segregated into taxable income, non-taxable income and capital gains. Further in case of an insurance company also carries on pension business, the same is taxed separately.

In case a combined life insurance fund being maintained by the insurer, the income in respect of each segment of business has to be separately worked out while determining taxable income.

With regards to "Allowable Expenses," normal rules are applied to deduct expenses from taxable income. Expenses should be allocated to various segments of the business and if a particular segment income is not taxable, the corresponding expenditure is also not allowed as deduction even from other segments.

During the initial years of insurance business, Expenses generally would more much more than income, resulting in taxable income being negative. In some countries, there is a cap on maximum allowable expenses which can be deducted from Taxable Income. In India also, the Income Tax Act 1961, before its amendment in 1977, provided in Rule 2(a) of the First Schedule, that the management expenses would be limited to 90 per cent of first year premium and 15 per cent of renewal premium.

> Unlike other commercial organisations, the concept of "Profit" cannot be ascertained in life insurance companies with certainty.

Similarly claims and other operating expenses are allowed as expenditure and balance of Income over expenditure is considered as Taxable Income.

Valuation Surplus Method :

Another method for used for levying tax on insurance companies is based on valuation surplus disclosed in the actuarial valuation in accordance with the provisions of Insurance Act, 1938.This valuation surplus will be reduced by the carried over surplus of previous years as the same could have taxed in those concerned years.

Expenses of insurance business will be debited to the fund before arriving at the surplus. Hence no special treatment would be necessary for the same. In some countries, some part of the surplus is exempt and balance will be considered for tax purposes. For example, before the Income Tax Act was amended in 1977, Section 3 (a) of the First Schedule to the Income tax Act, 1961, provided that 80 per cent of the surplus reserved for the policyholders could be deducted from the valuation surplus to arrive at the taxable surplus.

Comparison of the two methods:

If the former method (i.e. Investment Income Method) is adopted, a new life insurance company would not have to pay tax for quite a few years (for 10-15 years), till the fund size is increased and considerable investment income is generated which will absorb the expenses and resulting in taxable income. However in this method, a dispute may arise as to admissibility of expenses between the tax authorities and the insurer.

Under the surplus method, tax is levied on the valuation surplus arrived as per the provisions of the Insurance Act, which will be distributed between shareholders and policyholders as based on some percentages.(At present 90 per cent to policyholders and 10 per cent to shareholders). The surplus method of taxation is considered to be simpler than income less expenditure method.

Taxation method followed now:

The First Schedule to the Income tax Act 1961 was amended in 1977 to tax insurance companies (At that time only Life Insurance Company of India (LIC).

The series on ratio analysis, 'Keeping Count,' by Mr. P. S. Prabhakar will be resumed in the next issue.

This Schedule prescribes surplus as arrived at by actuary as per the provisions of the Insurance Act should be considered as profits and of Life Insurance Business.

Section 115B deals with tax rate to be applied for life insurance business and reads as below :

1. The amount of income-tax calculated on the amount of profits and gains of the life insurance business included in the total income, at the rate of twelve and one-half per cent ; and

2. Rhe amount of income-tax with which the assessee would have been chargeable had the total income of the assessee been reduced by the amount of profits and gains of the life insurance business.

Accordingly policyholders' surplus is taxable at 12.5 per cent and shareholders' profit is taxable at the corporate rate of tax.

Constitution of expert panel on life insurance taxation :

The Government of India in April 2000 constituted a 11 member Expert Panel on Taxation of Life Insurance sector under the chairmanship of Mr.Y.U. Eradi (former chairman of CBDT) to examine various aspects of taxation of life insurance companies in the wake of opening of insurance business to private sector. It appears that the Committee opined that policyholders' income (Surplus) should be taxable at a soft rate and shareholders' income should be taxable at the rate equivalent to commercial units. The committee submitted its report in the February 2001 and the Government is yet to take a view on it.

Insurers are expecting an amendment in the present tax law based on the recommendations of the Eradi Committee. Given this, they are not recognising Deferred Tax or Liability in their annual accounts as required by Accounting Standard 22.

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

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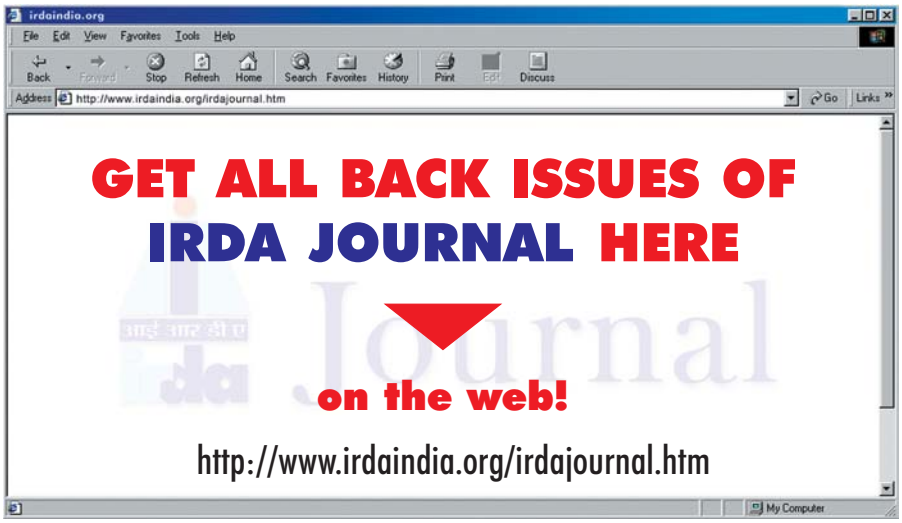

Vision - 2006

However, no prizes for guessing which sector is making a silent healthy contribution to this magic figure of eight per cent. Yes, it's insurance that has become the magic word in terms of contribution to GDP, job avenues, platform for foreign investment, incentive for savings and lots more.

A paradigm shift has already been witnessed with the liberalisation wave sweeping the insurance sector and a lot of private players entering the fray. In fact it is the insurance industry that has given the boost to the economy before it picked up recently. The opening up of the insurance industry to private players has contributed immensely to employment compared to all other sectors, quality of insurance, education, proliferation of distribution networks and branches, and increased awareness among the middle income sections of this gargantuan population.

Post liberalisation, the general insurance industry has not only been growing, but the private players are fast stealing the show. The eight private players have already captured a market share of 14 per cent and are perfectly poised to raise that figure to 20 per cent by next year. Aggressive marketing of their innovative policies, post sale service, CRM and wider opportunities to tap the large uninsured population have been instrumental in enabling them to grow at an astounding pace.

Though the growth rate of the private players cannot be absolutely compared with those of their national counterparts, as the private companies operate on a smaller base in terms of capital and customers, wide ranging distribution networks, stiff competition and computerised working environment have given them the leverage over their rivals.

It's been rosy so far in terms of performance for the private players. Now let us stretch our imagination and visualise how the scene will look like by 2006. As regards the private players, the stars are likely to favour them and help them achieve the 20 per cent mark quite easily. On the national front, the four state owned companies were hit by a devastating blow with about 4,500 employees leaving them consequent to the lucrative VRS in the first round. A similar number left by the close of the last financial year.

While the intentions of the national players was to trim the workforce, the scheme seems to have back-fired terribly as bulk of the employees leaving them are from the managerial and middle-management cadre. How the national players gear themselves up for the battle that is hotting up between themselves on the one hand and collectively against the new entrants on the other will be an absolute treat for keen industry observers.

With VRS on one side and new regulations, new players, new intermediaries (brokers) on the other, the insurance industry is set for a complete changeover. The competition is likely to get intensified once the de-tariffing legislation is passed and brokers firmly establish themselves as the vital link between the insurer and the insured. With over 150 licenses already issued, the future is going to be ruled by the brokers, particularly if they succeed in tapping the middle income and rural sections of this highly potential market. Brokers will have a significant role in imitating their global counterparts by rendering customised services satisfying the needs of various segments of customers.

How successful they are in their endeavours, will they be able to face competition from the established agents of companies, will they be able to bring in more transparency and make the market more regulated, will they be able to win customers, only time will tell. Or should I say, the curtains will be lifted by 2006 !

Karthik Amarnath

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India has the potential to be one of the largest pension markets in the world.

Mr. Sanjay Sachdev, Managing Director, Principal Mutual Fund,Indian subsidiary of Principal Financial Group, one of the biggest providers of retirement plans to US companies.

In the last few years, the insurance markets have seen severe losses,great price rises and now, record profits,all in swift succession. You might be excused for asking, just what on earth is going on? What we have witnessed in recent years is a highly volatile insurance market, which is a bad thing for businesses. The volatility means that insurance buyers can't plan financially for their insurance needs – or even be guaranteed that coverage will be available.

Lord Peter Levene,
Chairman, Lloyd's of London

What you saw was a very creative attempt to get a double recovery. One of the lessons learned here is that creative lawyering will get you so far but no further.

Mr.David Boies, Attorney for Lloyd's of London in the World Trade Center case where the jury has decided in favour of insurers that the attacks on the twin towers was one incident and not two for determination of the claim amount.

This is a partial verdict. We are awaiting the decision with respect to Swiss Re, the largest insurer in the World Trade Center coverage. We will have no further comment while the jury continues to deliberate.

Mr. Howard Rubenstein, a spokesman for Mr. Larry Silverstein, lease holder of World Trade Center who was on the losing side of the verdict.

Today the major concern of the regulator is development of health insurance. Till now health insurance has been marketed by non-life insurers and the life insurance companies have not shown much eagerness except in the area of critical illness products. In India, retail insurance business has been prerogative of life companies and unless we are able to attract life companies to this area the growth of health insurance in the country will continue to be slow.

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

Insurance is the DNA of capitalism.
Mr. Joe Plumeri, Chairman, Willis, the world's third largest insurance broker.

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Events

6 - 8 June 2004
Venue: Kuala Lumpur, Malaysia
LOMA Strategic Issues Conference,

6 - 9 June 2004
Venue: Bermuda
World Insurance Forum 2004

7 – 12 June 2004
Venue: Pune
Health Care Management by National Insurance Academy (NIA), Pune

14 - 15 June 2004
Venue: Taipei
Construction & Engineering Insurance Conference

14 - 19 June, 2004
Venue: Pune
Workshop on Motor Third Party Claims by NIA.

16-19 June, 2004
Venue: Taipei
FAPARMO (Federation of Asia Pacific and African Risk Management Organisations) risk management conference

16 - 19 June 2004
Venue: Taipei
IFRIMA, FAPARMO & RMST International Risk & Insurance Management Conference

21-26,June 2004
Venue: Pune
IT - a Tool for Claims Management by NIA.

24 June, 2004
Venue: Mumbai
One-day Conference on 'Export Credit and Related Risks Exposure Management' organised by Asia Insurance Post in association with Export Credit Guarantee Corporation of India and National Insurance Academy, Pune

24-26 June 2004
Venue: Pune
Actuarial Aspects of Non Life Insurance by NIA.

28 June - 7 July 2004
Venue: Pune
Actuarial Practices in Life Insurance by NIA.

11 - 14 July 2004
Venue: London
International Insurance Society Conference

12 - 17 July 2004
Venue: Pune
Service Quality and Relationship Managment by NIA.

18 - 21 July 2004
Venue: Seoul
APRIA Conference

29 July 2004
Venue: Sydney
Australia and New Zealand Insurance Industry Awards 2004

26 - 28 July 2004
Venue: Pune
Network Management by NIA.

30 - 31 July 2004
Venue: Pune
Strategic Issues for Global Competition by NIA.