Volume VI, No. 7

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irda

Journal

Jun/Jul 2008

Towards **Better Transparency**
in Health Insurance...

बीमा विनियामक और विकास प्राधिकरण

Printed by Alapati Bapanna and
published by J. Hari Narayan on behalf of
Insurance Regulatory and Development Authority.

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Printed at Kala Jyothi Process Ltd.
(with design inputs from Wide Reach)
1-1-60/5, RTC Cross Roads
Musheerabad, Hyderabad - 500 020
and published from
Parisrama Bhavanam, III Floor
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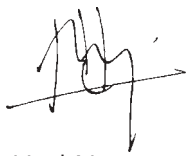
From the Publisher

In a country where most of the healthcare expenditure is by way of out-of-pocket expenses, the most gratifying thing to find is the rapid growth of the health insurance portfolio; and this is exactly what has been happening in the Indian scenario. The year end business figures for the recently concluded financial year reveal a whopping 60% growth of health insurance over the previous year's figures. Also considering the fact that as a portfolio, health insurance is very young; it is doubly significant. The growth speaks volumes of how insurers have been promoting this particular class of business. It also bears silent testimony to the fact that there has been a general rise in the levels of understanding of the people, as far as the importance of health insurance is concerned. All this augurs very well for an economy where access to healthcare still remains a distant dream to several millions.

All the same, it is not to be interpreted that health insurance as a class is devoid of all the complications that are normally associated with it and everything is hunky-dory. Some of the ills in this domain continue to exist and in fact, health insurance has been in the news more for the customer grievances rather than any other factor. Particularly, providing health insurance for senior citizens, and at affordable premiums, at that, is one area that has been hogging limelight and unless the insurance industry tackles the issue at this early stage, it is possible that it would flare-up into a raging controversy. With better clarity having been achieved in the area of premium rates and the incidence of pre-existing diseases, it is hoped that several of the misgivings in the domain would be put to rest.

The policyholders should also understand the basic tenets of insurance contracts in order to be able to better appreciate the complexities involved in the settlement of claims. Resorting to buying of insurance in order to pay for an impending calamity is nothing short of defrauding an insurer, although it is not very easy to make it sound convincing. Perhaps raising the levels of insurance awareness in the general masses would be helpful in solving this problem to a great extent.

The focus of this issue is once again on 'Health Insurance'. Having entered into a contract for a certain number of years and then not honouring the commitment to pay the premiums leads to a no-win situation. 'Lapsation in Life Insurance Contracts' will be the focus of the next issue of the **Journal**.



J. Hari Narayan

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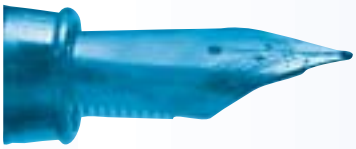
ISSUE FOCUS



The Changing Face of Health Insurance

The rapid strides of progress that health insurance has been making in recent times is the best thing to have happened in a nascent market like India. In a domain where protection against risks, especially in personal lines, is not a major priority; the remarkable growth of health insurance is a very positive sign of moving towards voluntary purchase of insurance, rather than a sales-driven model. Considering the huge potential, one can be sure that this trend will continue in the next few years, eventually making health insurance a household name. Making the masses, in particular, and also the literate classes of the society understand the benefits of insurance would certainly take this further.

The controversies associated with health insurance like denial of coverage, repudiation of claims etc. however, continue to make news. While there have been incidences of attempts to defraud insurers, adopting a hard line of approach with every claim that comes up for payment would lead to avoidable hardship for the policyholder, and undue publicity. All the forces involved must join hands to ensure that the problems associated particularly with health insurance are reduced to the minimum level. The policyholders, on their part, should understand clearly that health insurance contracts are in place to protect them from sudden and unforeseen expenses owing to hospitalization. Tendencies to enforce a claim or to enlarge the scope of a genuine claim must be curbed as they are detrimental to their own interests; and to the growth of the industry in the long run.

Health Insurance is the focus of this issue of the **Journal**. To begin with, we have the key recommendations of the CII working groups on health insurance. Mr. Aloke Gupta writes about the operation of Health Savings Account in different domains and its relevance in the Indian context. The availability of data is highly important for the success of insurance business. Mr. Alam Singh makes an in-depth study of how reliable data can be generated and analyzed that would make the Indian health insurance sector more successful and customer-friendly.

Despite the remarkable growth that health insurance has been witnessing in more recent times, there is no denying the fact that the industry has been confronting a few hiccups. Mr. G.V. Rao throws light on some of the problem areas and how the insurers have to align themselves to get over the irritants. Mortality and morbidity trends are two totally different aspects; and as a result, underwriting in health insurance throws a different challenge from that of a life insurance proposal. This parameter is brought home lucidly in the next article by Mr. R. Krishna Murthy and Ms. Gayle Adams. Apart from the usual monthly business figures of life and non-life insurers, the year-end sector-wise statistics of all the players also find a place in this issue.

Business retention ratio of life insurers is a very important measure of the success of the life insurers. However, lapsation of contracts due to a host of reasons continues to be a worrisome factor. The focus of the next issue of the **Journal** will be on 'Lapsation of Life Insurance Contracts' and we will be bringing for you varied opinions on this sensitive subject.

Mr. J. Hari Narayan assumed charge as the Chairman of the IRDA on 12th June, 2008, consequent upon the retirement of Mr. C.S. Rao. We present a quick profile of the new Chairman in this issue. We wish him the best of luck in taking IRDA to new heights; and look forward to his constant guidance.

U. Jawaharlal

Owing to office exigencies, we could not bring out the June issue of the Journal in time; and had to merge the June and July issues, as a result. We regret the inconvenience caused to our readers. – *Editor*

Report Card:LIFE

First Year Premium of Life Insurers for the Period Ended April, 2008

Sl No.	Insurer	Premium u/w (Rs. in Crores)			No. of Policies / Schemes			No. of lives covered under Group Schemes		
		April, 08	Up to April, 08	Up to April, 07	April, 08	Up to April, 08	Up to April, 07	April, 08	Up to April, 08	Up to April, 07
1	**Bajaj Allianz**									
	Individual Single Premium	10.68	10.68	7.84	4078	4078	2841			
	Individual Non-Single Premium	176.17	176.17	115.07	119263	119263	94862			
	Group Single Premium	0.16	0.16	0.62	0	0	0	303	303	528
	Group Non-Single Premium	0.76	0.76	0.71	59	59	19	48020	48020	78735
2	**ING Vysya**									
	Individual Single Premium	2.31	2.31	1.66	280	280	105			
	Individual Non-Single Premium	27.14	27.14	19.96	12149	12149	13586			
	Group Single Premium	0.48	0.48	0.00	0	0	0	98	98	0
	Group Non-Single Premium	0.26	0.26	0.13	6	6	0	1844	1844	8721
3	**Reliance Life**									
	Individual Single Premium	43.60	43.60	2.73	12289	12289	819			
	Individual Non-Single Premium	95.12	95.12	28.11	68041	68041	25081			
	Group Single Premium	17.08	17.08	1.07	3	3	4	14411	14411	5379
	Group Non-Single Premium	2.12	2.12	1.36	34	34	25	65054	65054	29601
4	**SBI Life**									
	Individual Single Premium	37.88	37.88	26.44	5321	5321	3707			
	Individual Non-Single Premium	110.57	110.57	51.88	33294	33294	18660			
	Group Single Premium	12.37	12.37	9.27	0	0	0	6834	6834	5659
	Group Non-Single Premium	11.09	11.09	2.73	4	4	1	21246	21246	15973
5	**Tata AIG**									
	Individual Single Premium	5.17	5.17	1.63	1201	1201	247			
	Individual Non-Single Premium	71.51	71.51	39.27	53014	53014	32661			
	Group Single Premium	3.81	3.81	5.06	1	1	0	16365	16365	33522
	Group Non-Single Premium	17.84	17.84	1.96	10	10	5	24075	24075	17203
6	**HDFC Standard**									
	Individual Single Premium	8.69	8.69	5.42	4714	4714	2080			
	Individual Non-Single Premium	96.93	96.93	56.92	31821	31821	22685			
	Group Single Premium	13.91	13.91	1.61	21	21	4	38996	38996	13947
	Group Non-Single Premium	0.86	0.86	6.65	0	0	3	24	24	10679
7	**ICICI Prudential**									
	Individual Single Premium	18.72	18.72	20.86	3225	3225	3371			
	Individual Non-Single Premium	244.46	244.46	169.22	206442	206442	116113			
	Group Single Premium	47.03	47.03	37.65	55	55	21	23966	23966	2886
	Group Non-Single Premium	34.58	34.58	43.70	144	144	75	107887	107887	40774
8	**Birla Sunlife**									
	Individual Single Premium	1.26	1.26	1.47	8136	8136	2042			
	Individual Non-Single Premium	85.40	85.40	23.94	24429	24429	11695			
	Group Single Premium	0.22	0.22	0.24	0	0	1	1114	1114	197
	Group Non-Single Premium	5.07	5.07	2.80	6	6	4	4875	4875	5944
9	**Aviva**									
	Individual Single Premium	1.25	1.25	1.85	174	174	219			
	Individual Non-Single Premium	36.94	36.94	33.68	14375	14375	11450			
	Group Single Premium	0.01	0.01	0.32	0	0	0	23	23	92
	Group Non-Single Premium	3.53	3.53	2.75	3	3	1	45913	45913	28616

10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	1.60	1.60	1.09	153	153	122			
	Individual Non-Single Premium	43.20	43.20	22.15	22298	22298	7041			
	Group Single Premium	0.85	0.85	0.77	1	1	0	8302	8302	6205
	Group Non-Single Premium	3.62	3.62	2.33	41	41	24	28537	28537	48379
11	**Max New York**									
	Individual Single Premium	17.27	17.27	11.95	1013	1013	793			
	Individual Non-Single Premium	94.16	94.16	56.58	69149	69149	41115			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	7.74	7.74	0.52	64	64	70	223162	223162	29497
12	**Met Life**									
	Individual Single Premium	0.24	0.24	0.48	42	42	97			
	Individual Non-Single Premium	68.71	68.71	17.66	12113	12113	3973			
	Group Single Premium	1.15	1.15	0.85	2	2	7	5399	5399	29765
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
13	**Sahara Life**									
	Individual Single Premium	1.75	1.75	0.54	442	442	157			
	Individual Non-Single Premium	3.01	3.01	1.22	3091	3091	2004			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
14	**Shriram Life**									
	Individual Single Premium	16.18	16.18	1.40	2799	2799	318			
	Individual Non-Single Premium	12.28	12.28	3.14	6021	6021	1930			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
15	**Bharti Axa Life**									
	Individual Single Premium	0.38	0.38	0.00	84	84	0			
	Individual Non-Single Premium	8.71	8.71	0.72	6163	6163	777			
	Group Single Premium	0.70	0.70	0.00	1	1	0	227	227	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
16	**Future Generali Life**									
	Individual Single Premium	0.01	0.01		1	1				
	Individual Non-Single Premium	0.03	0.03		127	127				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.58	0.58		2	2		7514	7514	
17	**IDBI Fortis Life**									
	Individual Single Premium	3.19	3.19		433	433				
	Individual Non-Single Premium	1.87	1.87		695	695				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
	Private Total									
	Individual Single Premium	**170.17**	**170.17**	**85.34**	**44385**	**44385**	**16918**			
	Individual Non-Single Premium	**1176.22**	**1176.22**	**639.53**	**682485**	**682485**	**403633**			
	Group Single Premium	**97.77**	**97.77**	**57.45**	**84**	**84**	**37**	**116038**	**116038**	**98180**
	Group Non-Single Premium	**88.06**	**88.06**	**65.64**	**373**	**373**	**227**	**578151**	**578151**	**314122**
18	**LIC**									
	Individual Single Premium	366.56	366.56	493.56	84152	84152	145327			
	Individual Non-Single Premium	730.20	730.20	1250.29	992055	992055	1443678			
	Group Single Premium	151.13	151.13	390.47	660	660	679	718445	718445	179722
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	**536.73**	**536.73**	**578.90**	**128537**	**128537**	**162245**			
	Individual Non-Single Premium	**1906.42**	**1906.42**	**1889.82**	**1674540**	**1674540**	**1847311**			
	Group Single Premium	**248.90**	**248.90**	**447.92**	**744**	**744**	**716**	**834483**	**834483**	**277902**
	Group Non-Single Premium	**88.06**	**88.06**	**65.64**	**373**	**373**	**227**	**578151**	**578151**	**314122**

Note: 1. Cumulative premium upto the month is net of cancellations which may occur during the free look period.
2. Compiled on the basis of data submitted by the Insurance companies

FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE YEAR ENDED MARCH 2008

INDIVIDUAL SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs.in Crore)

Sl. No.	PARTICULARS	PREMIUM		POLICIES		SUM ASSURED	
		Mar 2007	Mar 2008	Mar 2007	Mar'2008	Mar 2007	Mar 2008
	*Non linked**						
1	*Life*						
	with profit	291.20	169.03	26200	22549	386.87	289.64
	without profit	784.28	217.84	485730	433831	3987.38	2991.66
2	General Annuity						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	12.55	14.20	642	1296	0.68	0.25
3	Pension						
	with profit	159.57	122.63	10178	13575	2.52	21.79
	without profit	2.26	0.00	100	0	1.95	0.00
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
A.	Sub total	1249.85	523.69	522850	471251	4379.40	3303.34
	*Linked**						
1	*Life*						
	with profit	0.00	0.00	1	0	0.00	0.00
	without profit	4342.15	5999.73	764066	1310739	7062.59	11121.06
2	General Annuity						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	1.20	0.00	0	82	0.00	0.81
3	Pension						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	17952.47	22239.18	5430530	6658486	3.63	123.50
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
B.	Sub total	22295.83	28238.91	6194597	7969307	7066.22	11245.37
C.	Total (A+B)	23545.68	28762.61	6717447	8440558	11445.61	14548.71
	Riders:						
	Non linked						
1	Health#	0.04	0.03	32	31	0.57	0.27
2	Accident##	0.06	0.02	1050	116	7.07	1.22
3	Term	0.01	0.00	33	11	0.25	0.21
4	Others	0.00	7.54	0	0	0.00	-0.11
D.	Sub total	0.10	7.59	1115	158	7.90	1.59
	Linked						
1	Health#	0.04	0.03	89	21	1.04	0.25
2	Accident##	0.16	0.45	13043	24615	84.56	346.11
3	Term	0.00	0.00	8	0	0.12	0.00
4	Others	0.00	0.00	0	0	0.00	0.00
E.	Sub total	0.20	0.48	13140	24636	85.72	346.36
F.	Total (D+E)	0.31	8.07	14255	24794	93.62	347.95
G.	**Grand Total (C+F)	23545.99	28770.68	6717447	8440558	11539.23	14896.66

* Excluding rider figures.
** for policies Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders.
The premium is actual amount received and not annualised premium.

FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE YEAR ENDED MARCH 2008

INDIVIDUAL NON-SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs.in Crore)

Sl. No.	PARTICULARS	PREMIUM		POLICIES		SUM ASSURED	
		Mar 2007	Mar 2008	Mar 2007	Mar 2008	Mar 2007	Mar 2008
	*Non linked**						
1	*Life*						
	with profit	16484.03	9840.29	21169366	18519614	201760.82	177303.52
	without profit	1930.10	298.77	1048344	1175374	24442.02	25326.50
2	General Annuity						
	with profit	0.23	0.00	242	0	4.13	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
3	Pension						
	with profit	48.61	36.35	25323	41902	187.93	410.22
	without profit	21.23	20.04	6337	7280	0.00	0.00
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	27.88	89.68	169703	356419	7604.73	32422.40
A.	Sub total	18512.07	10285.14	22419315	20100589	233999.62	235462.65
	*Linked**						
1	*Life*						
	with profit	0.18	-0.18	87	6	1.96	0.13
	without profit	16627.45	30145.65	15704231	19105678	215674.25	292981.97
2	General Annuity						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
3	Pension						
	with profit	0.09	0.02	8	7	0.00	0.00
	without profit	2737.74	9309.01	1287337	3202084	1694.83	5708.60
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
B.	Sub total	19365.45	39454.50	16991663	22307775	217371.03	298690.71
C.	Total (A+B)	37877.53	49739.64	39410978	42408364	451370.66	534153.35
	Riders:						
	Non linked						
1	Health#	3.77	3.80	20553	12069	287.96	459.91
2	Accident##	6.79	5.82	419127	201096	6969.34	4673.21
3	Term	0.53	1.15	8884	3468	95.09	276.47
4	Others	17.65	2.10	4814	1205	2466.35	45.42
D.	Sub total	28.73	12.87	453378	217838	9818.74	5455.01
	Linked						
1	Health#	5.33	3.77	18806	18040	601.54	1031.60
2	Accident##	7.96	23.77	192737	218454	10907.00	13577.29
3	Term	1.70	0.41	20881	8536	585.88	134.32
4	Others	1.27	1.57	22573	3727	1095.28	510.82
E.	Sub total	16.25	29.51	254997	248757	13189.70	15254.03
F.	Total (D+E)	44.99	42.38	708375	466595	23008.44	20709.04
G.	**Grand Total (C+F)	37922.51	49782.02	39410978	42408364	474379.10	554862.39

* Excluding rider figures.
** for policies Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders.
The premium is actual amount received and not annualised premium.

FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE YEAR ENDED MARCH 2008

GROUP SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs.in Crore)

Sl. No.	PARTICULARS	PREMIUM		NO. OF SCHEMES		LIVES COVERED		SUM ASSURED	
		Mar 2007	Mar 2008	Mar 2007	Mar 2008	Mar 2007	Mar 2008	Mar 2007	Mar 2008
	*Non linked**								
1	**Life**								
a)	Group Gratuity Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	2473.23	3667.87	2287	2298	926223	1176859	4086.88	5964.02
b)	Group Savings Linked Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	30.89	18.32	1022	594	281244	145310	2163.39	1163.51
c)	EDLI								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	5.69	6.28	1047	989	923126	1163439	2585.38	4897.40
d)	Others								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	6477.96	2384.66	16296	18536	12708409	25480209	258470.93	104920.01
2	**General Annuity**								
	with profit	1039.19	834.69	9	6	3525	1745	0.00	0.00
	without profit	883.32	1680.80	61	71	11275	11433	0.00	0.00
3	**Pension**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	1173.17	2517.19	239	422	101111	410395	0.00	0.00
4	**Health**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
A.	**Sub total**	12083.45	11109.81	20961	22916	14954913	28389390	267306.58	116944.95
	*Linked**								
1	**Life**								
a)	Group Gratuity Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	233.14	567.69	88	193	200027	221704	629.76	1580.28
b)	Group Savings Linked Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
c)	EDLI								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
d)	Others								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	15.62	45.98	4	11	13225	14755	1.32	1.48
2	**General Annuity**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
3	**Pension**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	89.15	147.96	18	28	12448	63549	0.00	0.00
4	**Health**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
B.	**Sub total**	337.90	761.63	110	232	225700	300008	631.09	1581.76
C.	**Total (A+B)**	12421.35	11871.44	21071	23148	15180613	28689398	267937.67	118526.71
	Riders:								
	Non linked								
1	Health#	0.40	0.49	19	21	9237	15085	0.00	731.38
2	Accident##	0.28	0.23	39	57	23415	33319	0.00	663.26
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
D	**Sub total**	0.68	0.73	58	78	32652	48404	0.00	1394.64
	Linked								
1	Health#	0.00	0.00	0	0	0	0	0.00	0.00
2	Accident##	0.00	0.00	0	0	0	0	0.00	0.00
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
E	**Sub total**	0.00	0.00	0	0	0	0	0.00	0.00
F	**Total (D+E)**	0.68	0.73	58	78	32652	48404	0.00	1394.64
G	****Grand Total (C+F)**	12422.04	11872.17	21071	23148	15180613	28689398	267937.67	119921.35

* Excluding rider figures.
** for no.of schemes & lives covered Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders.
The premium is actual amount received and not annualised premium.

FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE YEAR ENDED MARCH 2008

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

(Rs.in Crore)

Sl. No.	PARTICULARS	PREMIUM		NO. OF SCHEMES		LIVES COVERED		SUM ASSURED	
		Mar 2007	Mar 2008	Mar 2007	Mar 2008	Mar 2007	Mar 2008	Mar 2007	Mar 2008
	*Non linked**								
1	**Life**								
a)	*Group Gratuity Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	247.96	576.32	59	73	95517	91840	346.49	394.05
b)	*Group Savings Linked Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	44.34	101.24	0	5	446142	501934	7221.68	4501.45
c)	*EDLI*								
	with profit	0.00	1.11	0	106	0	111843	0.00	1007.61
	without profit	5.79	2.23	282	185	420048	212863	3599.31	1942.25
d)	*Others*								
	with profit	0.00	35.39	0	150	0	365390	0.00	9443.34
	without profit	314.68	260.92	1195	950	3348604	4280708	61621.13	63179.76
2	**General Annuity**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
3	**Pension**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	5.97	9.14	4	2	79	86	0.00	0.00
4	**Health**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
A	**Sub total**	618.74	986.35	1540	1471	4310390	5564664	72788.61	80468.45
	*Linked**								
1	**Life**								
a)	*Group Gratuity Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	473.52	959.77	369	395	361554	660708	2122.81	3557.59
b)	*Group Savings Linked Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	3.77	0	24	0	7285	0.00	89.91
c)	*EDLI*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
d)	*Others*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	11.39	33.32	14	22	167	4270	1.97	9.12
2	**General Annuity**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	38.26	28.03	12	12	2547	1107	38.26	28.03
3	**Pension**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	372.35	549.20	135	163	62451	59106	0.00	0.00
4	**Health**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
B	**Sub total**	895.52	1574.08	530	616	426719	732476	2163.04	3684.65
C	**Total (A+B)**	1514.26	2560.44	2070	2087	4737109	6297140	74951.65	84153.10
	Riders:								
	Non linked								
1	Health#	0.34	2.21	21	34	14141	30542	601.01	1739.19
2	Accident##	0.67	0.77	34	39	46185	56333	1936.96	2250.92
3	Term	0.00	0.01	1	1	114	61	8.03	0.63
4	Others	0.01	0.01	5	6	3987	2490	216.56	343.89
D	**Sub total**	1.02	3.00	61	80	64427	89426	2762.55	4334.62
	Linked								
1	Health#	0.00	0.00	0	0	0	0	0.00	0.00
2	Accident##	0.70	0.41	47	46	48838	60276	1635.54	608.09
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
E	**Sub total**	0.70	0.41	47	46	48838	60276	1635.54	608.09
F	**Total (D+E)**	1.72	3.41	108	126	113265	149702	4398.10	4942.72
G	**Grand Total (C+F)	1515.98	2563.84	2070	2087	4737109	6297140	79349.75	89095.81

* Excluding rider figures.
** for no.of schemes & lives covered Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders.
The premium is actual amount received and not annualised premium.

Report Card:LIFE

First Year Premium of Life Insurers for the Period Ended May, 2008

Sl No.	Insurer	Premium u/w (Rs. in Crores)			No. of Policies / Schemes			No. of lives covered under Group Schemes		
		May, 08	Up to May, 08	Up to May, 07	May, 08	Up to May, 08	Up to May, 07	May, 08	Up to May, 08	Up to May, 07
1	**Bajaj Allianz**									
	Individual Single Premium	26.10	36.77	34.57	5779	9317	8290			
	Individual Non-Single Premium	259.84	436.01	369.06	175325	293899	297389			
	Group Single Premium	0.21	0.37	1.41	0	0	0	326	629	1216
	Group Non-Single Premium	11.90	12.66	3.43	21	80	44	386644	434664	96001
2	**ING Vysya**									
	Individual Single Premium	3.79	6.09	2.60	496	776	194			
	Individual Non-Single Premium	48.66	75.81	56.24	28722	40871	32962			
	Group Single Premium	1.63	2.11	0.85	0	0	0	321	419	168
	Group Non-Single Premium	0.06	0.33	0.73	9	15	2	1840	3684	23708
3	**Reliance Life**									
	Individual Single Premium	46.40	90.00	10.36	11164	23453	2288			
	Individual Non-Single Premium	143.63	238.75	80.00	80011	148052	54542			
	Group Single Premium	5.74	22.83	6.88	0	3	7	0	14411	7351
	Group Non-Single Premium	0.62	2.74	2.34	21	55	45	42507	107561	68373
4	**SBI Life**									
	Individual Single Premium	57.21	95.09	69.99	7757	13078	10114			
	Individual Non-Single Premium	171.67	282.24	143.53	49133	82427	51690			
	Group Single Premium	17.64	30.01	25.85	0	0	0	9562	16396	14337
	Group Non-Single Premium	127.91	139.00	30.27	8	12	6	200239	221485	51899
5	**Tata AIG**									
	Individual Single Premium	4.47	9.64	3.18	906	2107	451			
	Individual Non-Single Premium	78.17	149.68	81.80	48469	101483	67206			
	Group Single Premium	4.91	8.73	11.17	0	1	0	17943	34308	72320
	Group Non-Single Premium	2.92	20.76	4.36	7	17	7	11374	35449	34062
6	**HDFC Standard**									
	Individual Single Premium	11.62	20.31	13.98	8219	12933	12167			
	Individual Non-Single Premium	144.26	241.19	180.94	50199	82020	62676			
	Group Single Premium	5.40	19.75	3.26	11	32	12	13660	52656	16866
	Group Non-Single Premium	5.79	6.65	24.52	1	1	9	12147	12171	12803
7	**ICICI Prudential**									
	Individual Single Premium	27.21	45.93	50.38	5087	8312	8052			
	Individual Non-Single Premium	454.30	698.76	451.73	196035	402477	261716			
	Group Single Premium	12.95	59.97	46.75	26	81	41	63029	86995	55910
	Group Non-Single Premium	112.52	147.10	83.66	69	213	122	212065	319952	127925
8	**Birla Sunlife**									
	Individual Single Premium	4.61	5.87	4.67	12688	20824	6179			
	Individual Non-Single Premium	162.41	247.81	69.65	49598	73601	32844			
	Group Single Premium	0.14	0.36	0.41	0	0	2	441	1555	473
	Group Non-Single Premium	1.10	6.17	9.88	9	15	8	9347	14222	6846
9	**Aviva**									
	Individual Single Premium	1.86	3.12	3.26	296	470	473			
	Individual Non-Single Premium	62.99	99.94	83.60	29859	44234	34742			
	Group Single Premium	0.00	0.01	0.71	0	0	0	28	51	242
	Group Non-Single Premium	0.29	3.83	4.07	10	13	11	7889	53802	60357

10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	2.03	3.63	2.74	285	438	344			
	Individual Non-Single Premium	79.78	122.98	58.14	39993	62291	22340			
	Group Single Premium	2.00	2.85	2.12	0	1	0	10168	18470	12182
	Group Non-Single Premium	2.52	6.14	4.51	37	78	39	799103	827640	65720
11	**Max New York**									
	Individual Single Premium	26.62	43.89	28.53	2292	3305	1704			
	Individual Non-Single Premium	160.48	254.64	125.78	115528	184677	88579			
	Group Single Premium	0.11	0.11	0.00	5	5	0	1257	1257	0
	Group Non-Single Premium	5.28	13.01	2.16	37	101	100	106458	329620	44129
12	**Met Life**									
	Individual Single Premium	0.40	0.64	3.20	101	143	465			
	Individual Non-Single Premium	52.96	121.67	48.61	15841	27954	15519			
	Group Single Premium	1.26	2.42	1.93	10	12	10	31358	36757	36152
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
13	**Sahara Life**									
	Individual Single Premium	2.88	4.62	2.02	752	1201	569			
	Individual Non-Single Premium	6.19	8.73	4.46	6773	9902	7484			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.00	0.00	1	1	0	27	27	0
14	**Shriram Life**									
	Individual Single Premium	17.27	33.46	9.54	2629	5428	2025			
	Individual Non-Single Premium	9.48	21.76	15.71	4622	10643	7862			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
15	**Bharti Axa Life**									
	Individual Single Premium	0.63	1.01	0.04	222	303	4			
	Individual Non-Single Premium	14.35	23.06	2.24	11653	17360	2306			
	Group Single Premium	0.28	0.98	0.00	1	1	0	125	352	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
16	**Future Generali Life**									
	Individual Single Premium	0.00	0.01		0	1				
	Individual Non-Single Premium	0.65	0.68		1751	1878				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.41	0.99		5	7		7481	14995	
17	**IDBI Fortis Life**									
	Individual Single Premium	5.72	8.92		777	1208				
	Individual Non-Single Premium	3.99	5.86		1879	2570				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
	Private Total									
	Individual Single Premium	**238.82**	**408.98**	**239.06**	**59450**	**103297**	**53319**			
	Individual Non-Single Premium	**1853.80**	**3029.55**	**1771.50**	**905391**	**1586339**	**1039857**			
	Group Single Premium	**52.29**	**150.50**	**101.34**	**53**	**136**	**72**	**148218**	**264256**	**217217**
	Group Non-Single Premium	**271.32**	**359.38**	**169.93**	**235**	**608**	**393**	**1797121**	**2375272**	**591823**
18	**LIC**									
	Individual Single Premium	732.60	1099.16	1320.35	156392	240544	376187			
	Individual Non-Single Premium	1167.81	1898.00	2759.88	1504485	2496540	3309588			
	Group Single Premium	1022.58	1173.71	969.64	985	1645	2047	869355	1588529	2419311
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	**971.42**	**1508.14**	**1559.41**	**215842**	**343841**	**429506**			
	Individual Non-Single Premium	**3021.61**	**4927.56**	**4531.38**	**2409876**	**4082879**	**4349445**			
	Group Single Premium	**1074.86**	**1324.20**	**1070.98**	**1038**	**1781**	**2119**	**1017573**	**1852785**	**2636528**
	Group Non-Single Premium	**271.32**	**359.38**	**169.93**	**235**	**608**	**393**	**1797121**	**2375272**	**591823**

Note: 1.Cumulative premium upto the month is net of cancellations which may occur during the free look period.
2. Compiled on the basis of data submitted by the Insurance companies

Profile

Mr. Hari Narayan was born in Mumbai in 1948 and he is the 3rd son of Late Mr. J.B. Rao and Mrs. Kamala Bai. His father worked in Indian Railways from where he ultimately retired in 1970 as Additional Member of the Railway Board. In the course of his illustrious career, he had served in several parts of India and consequently Mr. Hari Narayan's education was in Chennai and in Delhi - in three spells at each city. He earned a B.Sc (Hons.) in Physics from St. Stephen's College, Delhi and an MA in History from Madras Christian College, Chennai; and subsequently joined the IAS in 1970.

Mr. Hari Narayan has served in several districts in Andhra Pradesh including Khammam, Nizamabad, Karimnagar, Srikakulam, Krishna and Cuddapah. He served for many years in the fields of public enterprises management, infrastructure sector development and in industrial financing. He has been Managing Director of the Leather Industries Corporation, Small Scale Industries Development Corporation and the Industrial Development Corporation of the Government of Andhra Pradesh. He has also served in the Electricity Board, the Singareni Collieries and in the Steel Industry. He was also the MD of the Irrigation Development Corporation and Principal Secretary, Irrigation. Mr. Hari Narayan has served in the Government of India as Under Secretary in the Ministries of Defence and Education; as Joint Secretary in the Ministries of Coal and Food Processing; as Additional Secretary in the Ministry of Rural Development; and as Secretary to the Government of India in the Ministries of Programme Implementation and Statistics; and in the Ministry of Water Resources. Finally he was appointed as Chief Secretary to the Government of Andhra Pradesh in 2006 from where he superannuated in February, 2008.

In his career, Mr. Hari Narayan was involved in very many notable events, some of which are – the first privatization of a large scale public sector industry in India, namely, the Hyderabad Allwyn Limited; the evolution and design of the E-procurement system of the Government of Andhra Pradesh while he was serving as the Principal Secretary, Irrigation etc.

As MD, AP Small Scale Industries Corporation, he provided the impetus for the development of the Cherlapalli Industrial Estate which has now grown into a very significant industrial hub. As MD of the APIDC, he enabled the commencement of the Software Technology Park in Hyderabad which was a building block of the Hyderabad software industry. Mr. Hari Narayan has led the Indian team in the negotiations of various aspects of the WTO negotiations in relation to Trade in Processed Foods and related matters. As Secretary, Water Resources to the Government of India and as Chief Secretary to the Government of Andhra Pradesh, he led the Indian team to International Tribunal for the resolution of a major dispute with Pakistan on matters arising out of the Indus Waters Treaty.

Mr. Hari Narayan is involved with many Non-Governmental Organizations working in the fields of Rural Development and Care for the Elderly. He is a great music lover and keenly listens to different forms of classical music.

Mr. Hari Narayan is married to Mrs. Kameswari and they have a daughter. Mrs. Kameswari is a well-known international and national consultant in the field of education, particularly for the education and training of adolescent girls in Rural India.

Lapsation in Life Insurance

The No-Win Deal

'LAPSATION OF A LIFE INSURANCE CONTRACT LEADS TO LOSS OF PRECIOUS RESOURCES BOTH FOR THE INSURER AS WELL AS THE INSURED. THERE IS A SERIOUS NEED FOR HIGHLIGHTING THE EVILS ASSOCIATED WITH A LAPSE; AND THIS SHOULD LEAD TO BETTER BUSINESS RETENTION RATIOS OF LIFE INSURERS' EMPHASIZES U. JAWAHARLAL.

Insurance contracts are said to be synallagmatic in nature thereby indicating that there is a large emphasis on the reciprocal obligations of the two parties. The non-fulfillment of the obligations by any of the parties would naturally lead to a breach of contract that would render the contract null and void. This is particularly of major significance in life insurance contracts which are essentially long term in nature. Discontinuance of the payment of premium by the life assured for whatever reason leads to the 'lapse' of a life insurance contract.

Lapsation in life insurance contracts is an undesirable event – for the policyholder as well as the insurer. In view of the unilateral breach of contractual obligations, normally no sum of money is payable to the policyholder in the event of a lapse. However, in the case of policies that have a savings component; life insurers usually compensate the policyholders to some extent if the contract has been in force for a certain period. This is understandably so in light of the fact that the expenses upfront are very huge. In any case, the amount payable in case of lapsed contracts is limited to a part of the premium paid; and this acts as a strong deterrent for policyholders not to surrender their policies.

Looking at it from the other side, lapsation of life insurance contracts upsets the cash flow of the insurance companies; and the commitments they have made in anticipation of the regular flow of premiums might take a beating. Further, it results in a break of the relationship with an existing customer and is replete with the costs and effort of recruiting new ones. Thus, it can be seen that lapsation is a no-win deal; and steps should be taken to ensure that it is limited to the bare minimum.

Life insurance companies should strive to collect and analyze the reasons for a high incidence of lapsation of their portfolio. A few companies have implemented practices of penalizing the distribution personnel for a heavy lapsation. This has certainly improved the business retention ratios of the companies. If the distributor has done his job meticulously by identifying the needs of the prospect, and then successfully completed a need-based selling; it is less likely that the contract would end up in a lapse. Another major malady associated with high lapsation ratios is rebating. When the policyholder has been lured into buying a policy by paying a huge rebate upfront, there is a tendency to discontinue payment of premiums. Further, there is also a need to make the policyholders realize the evils associated with making their contracts lapse. Insurers should highlight the benefits of the free-look period and ensure that the policyholders really make use of it so that any misunderstanding as regards their needs is sought to be settled upfront.

'Lapsation in Life Insurance Contracts' will be the focus of the next issue of the **Journal**; and we look forward to a lively debate on this issue.

Breaking a Promise

in the next issue...

CII Working Groups on Health Insurance - Key Recommendations

Given below are the extracts from the key recommendations presented and circulated by the CII working groups on health insurance, at a workshop in Mumbai on 9th May 2008. The working groups were formed after the CII Health Insurance Summit in October 2007 and the groups worked in close co-ordination with IRDA. The recommendations represent the consensus of the group members after several rounds of deliberations on the various pertinent issues being discussed by each of the groups.

THE DATA STANDARDS GROUP

Key recommendations

- The group concluded that the existing data with IRDA is of sufficient quality and quantity for extensive data analysis. If fully analyzed, this data can yield critical business intelligence which can significantly strengthen and grow the industry by providing a scientific rationale for most business decisions. The group suggested that the data submitted to the repository should be regularly analyzed under the guidance of a group of experts.
- IRDA can make available in the public domain, results of the detailed analysis. The analysis must include all parameters which are pertinent to consumers and other stakeholders in the industry and must be done on a regular basis.
- The group suggests that process of collecting data should be continued. In addition, the data collection system should be extended to cover all insurers (both life and general) selling health products. All insurers need to develop the systems and processes to submit data in the prescribed formats and at required accuracy levels. This will ensure that the data repository continues to have comprehensive data for meaningful analysis.
- IRDA should maintain the data repository and ensure compliance of data submission by the insurers and TPAs as per the regulatory provisions. For the first year, the frequency of data submission will be annual. In the second year, it will be bi-annual and quarterly from the third year onwards.
- The group suggests that the government should consider mechanisms for seeking healthcare provider's participation in the IRDA health data repository. The group has evaluated health information systems of few corporate hospitals and it is of the opinion that providers' data can significantly enrich the data repository. The group is specifically interested in obtaining insights into disease burden, for both the insured and uninsured population. The group suggests case mix reporting system by the providers, as in other countries, as a mechanism for obtaining data related to disease burden.
- Data from other entities like ESIS, Railways, etc. who runs self funded health plans could also be consolidated in the repository.
- A common standard claims format should be introduced for submitting health insurance claims. This will not only facilitate capturing of required information but also the quick settlement of claims. The group is in the advanced stage of devising such a format for consideration and implementation by IRDA.
- Unique Identification Number: In order to achieve high quality in the data submitted by the stakeholders and to ensure movement towards portability of health insurance, it is desirable that a unique identification number should be allotted to every insured. This will also prevent duplication of claims. The group suggests such UID systems based on biometrics (as is being done in RSBY) or PAN number. This can be further debated and implemented with necessary regulatory / legal changes.
- ICD-10 Codes: Standardized coding of diagnosis (using ICD-10 codes) and procedures (using ICD 9 PCS codes) must be strengthened. This will require continuous training of data entry operators, underwriters and claim settlement officers of insurance companies and TPAs. A simple drop-down ICD 10 coding tool to assist in training the staff of insurers / TPAs in easy assignment of diagnosis codes has been developed. The same will be distributed to insurers / TPAs at a later stage. IRDA should also coordinate additional training.
- For ensuring accuracy, completeness and timeliness of data submission, a regular inspection mechanism could be considered. Evaluation of an insurer's or TPA's data capturing system could be a licensing pre-requisite. Existing insurers and TPA's should be required demonstrate their IT capabilities in this regard.
- The group suggests unique identification of hospitals which could be done using GIS codes.
- Health Insurance is generally reported under Miscellaneous in the financial statements. Although health is treated as a separate vertical by most insurers, financial statements do not list health separately. The group suggests that Health Insurance should be listed as a separate line of business by the insurance companies, for better focus and better quality data.
- Health insurance should be a focus point for IRDA. IRDA should strengthen the health department and also consider a separate self regulatory organization like a Health Insurance Council.
- The group suggests a sample of 1 lakh records be put on the IRDA website for analysts / researchers. This will help in improvements in quality of data. Alternately, IRDA on request may provide data to researchers. In the latter case, the intention of IRDA may be made known to all by announcing it on its website. This should be done while preserving confidentiality of the insured, insurer and the TPA.

THE PROVIDERS STANDARD GROUP

Key recommendations

- The industry requires standard definitions to enable effective and unambiguous interaction amongst all stakeholders. The group has provided an illustrative set of definitions for common terms for further deliberation and adoption.
- Health care delivery consists of diverse practitioners and institutions, mixed ownership patterns and differing systems of medicine. In such a scenario, mechanisms such as certification, regulation, quality assurance programs, peer review, consumer education and developing accreditation systems are gaining prominence. The group suggests that norms need to be first evolved for categorization and grading of hospitals for insurance purposes. The group has suggested a criterion which can be used by TPAs / insurance companies for hospitals / providers. There's a need to ensure that the proposed standards are in alignment with other ongoing initiatives (e.g. National Council on Standards, BIS, etc).

- Presently, various TPAs have developed their own prior authorization forms. It was suggested that a common prior authorization form be developed. A recommended form format was developed by the group for deliberation and adoption.
- Standardized treatment guidelines (STGs) can assist in bringing about standardization of quality of care. Therefore the group supports the development of clinical guidelines. It will endeavor to:
  - Disseminate and advocate widespread use of STGs including refinement in methodology used.
  - Compile a list of top 50 conditions, most commonly reimbursed by insurance companies / TPAs.
  - Establish mechanisms for long-term collaboration on development of treatment guidelines and costing. This could include identification of potential collaborating partners / institutions.
  - It was felt that some short-term and long-term measures to enhance the use of ICD 10 need to be outlined. There is a need to create training infrastructure, modules and core trainers. The group suggests the use of ICD-9 procedure codes until the procedure codes for ICD 10 are finalized.
- The members of the group were requested to provide feedback on the draft Clinical Establishment Bill. It was proposed that CII / industry / industry chambers could facilitate the same.

THE PAYOR STANDARDS GROUP

Key recommendations

- To ensure that customers are not 'underwritten at claims stage', all health insurance business should be underwritten at policy inception, in a manner that is consistent with the pricing strategy and the risk appetite of the insurance company. The report details the various options available for underwriting and the link between the underwriting approach and premium levels paid by the customer.
- Each company would be required to specify an internal underwriting policy framework. This policy framework should articulate the overall risk philosophy of the company and should be approved by the Board of Directors of each insurance company. The report provides details of a best practice framework, which can be customized by each company.
- The underwriting policy would be captured in an underwriting manual, which should be updated for each new product launch - and should be included as part of the normal file and use process.
- To support the rollout of a best practice underwriting framework, a robust underwriting training framework should be developed.
- Each insurer should adopt a best practice claims management framework to create transparency in claims processing. Information about turn around times [TATs] should be made available to customers publicly and monitored by the IRDA.
- Each insurance company would be required to create a claims manual which would specify the claims philosophy of the company as well as the claims processing and management guidelines for each product.
- All commonly used health insurance terms must additionally be expressed in Common Business English as part of the policy kit sent to the customer. These are meant to be explanatory in nature only – they do not change the legal position of the insurance company.
- A standardized pre-authorization form should be used by all TPAs / insurance companies.
- Insurers should have the freedom to re-price the risk at a portfolio level, at the time of renewal. Re-pricing should be permitted for a class of policies and not at an individual policy level.
- The group also recommends additional focus on integration and interaction between payors and providers.
- Adoption of coding protocols; ICD 10 for diagnosis and ICD 9 PCS for procedures by insurance companies.
- Adoption of market level clinical protocols. This helps to provide clarity over what health insurance would finance – for specific ailments and surgeries, and for the development of guidance for reasonable and customary health expenses.
- Transparency to the customer about portability of benefits via a "Portability Disclosure" to be included as part of the policy terms and conditions.
- This portability disclosure would specify the extent to which a customer can get the benefit of continuing cover:
  - At policy renewal
  - Across individual insurance products sold by the same company
  - Across individual insurance products sold by different insurance companies

THE COMMUNICATION AND AWARENESS GROUP

Key recommendations

- Multiple awareness messages need to be designed. The criteria which will define the message are:
  - Is the message recipient someone who already has health cover or is an uninsured individual?
  - For uninsured individuals, initially, messaging will target those in the urban markets. Those in the rural segments will be targeted subsequently.

The key communication objectives should be:

- To explain what is health insurance and how it works. The objective would be to explain the philosophy of risk pooling.
- To educate the consumer on how to choose the right product and how to use it.
- To create a positive image of health insurance and its role in protecting against medical emergencies.
- To provide clarity on benefits of products/services and to explain the main terms and conditions and what health insurance covers or does not cover.
- To educate consumers about the process of grievance redressal.

- A group which can launch and maintain a sustained campaign should oversee this initiative. This group can be anchored by the Life Insurance Council and General Insurance Council and can function under the aegis of IRDA with representatives from insurance companies.
- The channels of communication which the group can use should be regional media, new media, in-program or in-film promotion and celebrity endorsement campaigns.

The Indian health insurance industry has grown significantly. Industry stakeholders will now steer its future growth through well coordinated initiatives which seek to develop systems and process for robust growth and a superior customer experience. CII and IRDA are committed to assisting the industry stakeholders meet the goals specified in this document.

Disclaimer: This document represents the views of the various working groups. These are not the specific views of either IRDA, CII or any one individual group member or the organization they work with.

Health Savings Account

Relevance to India

ALOKE GUPTA OPINES THAT HEALTH SAVINGS ACCOUNTS WITH TAX BENEFITS ATTACHED TO THEM ARE LIKELY TO ENCOURAGE PEOPLE TO START SAVING EARLY FOR THEIR OLD AGE HEALTH EXPENSES SINCE THEY WOULD HAVE AN INCENTIVE TO ACCUMULATE SUCH BALANCES.

Introduction

Health insurance in India has made rapid strides since the insurance liberalisation in 2001 with premiums growing from Rs.774 crore ($181.26 million) to Rs.3,300 crore ($772.83 million) in 2006-07. Health insurance premiums are expected to have grown to over Rs.4,000 crore ($936.77 million) at the close of the fiscal 2007-08. This translates into a compound annual growth rate of around 40 per cent. Correspondingly, penetration (percentage of population) covered under health insurance grew from 0.9 per cent to over 1.5 per cent during the same period, a wholly inadequate increase considering both, the disproportionate burden of healthcare expenses which individuals and households bear as a proportion of GDP i.e., around 4.0 per cent as against the small public healthcare spend of 0.9 per cent of the GDP.

Despite low health insurance penetration, the sector is plagued by growing consumer dissatisfaction mainly due to the claims settlement disputes arising out of interpretation by insurers of the 'pre-existing diseases/conditions'. In fact, health insurance is one of the most litigated areas of insurance today, which has created a 'crisis of trust' against the insurers by the health insurance policyholders. Other important issues that are crying to be addressed by the insurers marketing health insurance are:

- Lack of adequate coverage both by way of quantum of coverage as well as choice of products
- Escalating premiums adversely affecting affordability of cover
- 'Cream Skimming' by insurers
- Lack of transparency regarding exclusions relating to the pre-existing conditions/diseases
- Limited or no portability across insurers, products or from group to individual cover
- Arbitrariness about renewability and continuity of cover

Rapid escalation of healthcare costs in India during the past several years has led to widespread debate and demand for major reform in the nation's healthcare delivery system.

Need for Change - Health Savings Account (HSA)

Rapid escalation of healthcare costs in India during the past several years has led to widespread debate and demand for major reform in the nation's healthcare delivery system. One reason for the increase in healthcare costs can be attributed to increased use of technology in diagnosis and treatment, growing corporatisation of private healthcare, chronic shortfall of healthcare infrastructure leading to quality constraints in public healthcare delivery. To an extent, the current health insurance regime built on the premise of full insurance benefits i.e., no cost-sharing in the form of co-insurances and deductibles has contributed to price escalation at least in the private sector tertiary and secondary care. This has happened because healthcare providers normally tend to increase utilisations, especially under third party payor arrangements. Such arrangements obviate the need for consumers (patients) to be more concerned about medical expenses, in a way insulating them from prices. This has the effect of their not perceiving the true costs of healthcare services, to the society at large. Moreover, employer funded health insurance arrangements provide little, if any, incentive for employees to make cost-conscious purchasing decisions or pressure providers for greater economic efficiency

With growing medical inflation and richer benefits being demanded and offered during the annual wage-negotiation exercise, health insurance burden on employers has considerably increased.

in order to reduce the cost of healthcare delivery.

The philosophy behind an HSA is that each person or family funding a savings account for health expenses should always carry health insurance as a back-up in the event of a "catastrophic" type of medical situation. Different countries like USA, South Africa, Canada, Singapore, China and Hong Kong have experimented with this concept and have achieved success in varying degrees in HSAs being accepted as a viable and long-term option for financing healthcare expenses. However, there is no uniform architecture that the various proponents of HSA have adopted. Each of them have adopted and structured it as per the needs of their people.

This article, discusses the concept of Health Savings Account (HSA) as an instrument of meeting healthcare expenditures and its relevance to the Indian health insurance sector.

Health Savings Account – Combining Health Insurance with Savings

An HSA is a tax-exempt savings account similar to an Individual Pension Account, but earmarked for medical expenses. Deposits in the account are tax-exempt for the account holders and can be easily withdrawn to pay for routine medical bills HSA works in conjunction with a special "high-deductible" health insurance policy resulting in the provision of comprehensive health insurance coverage at the lowest possible net cost. The insurance company pays for major medical expenses (covered expenses in excess of the deductible amount) while the HSA account holder pays for the 'minor' medical expenses with tax-exempt money from his HSA. The HSA account holder has the freedom to use the HSA accumulations to pay for medical expenses not covered under the insurance policy, such as dental, vision and alternative medicines. Unutilized balances in the HSA can be accumulated towards individual retirement accounts.

HSA as it operates in different countries

USA – Large part of health insurance in the U.S. is employer funded group health insurance, where premiums paid by the employers are allowed tax privileges. However, with growing medical inflation and richer benefits being demanded and offered during the annual wage-negotiation exercise, health insurance burden on employers has considerably increased.

HSAs have provided a cheaper alternative to employers in financing the healthcare benefits of their employees. While moving to an HSA arrangement, the employer replaces the existing health insurance coverage to a catastrophic cover (which is less expensive) and transfers all or part of the premium savings to an employee's HSA account as annual contribution.

Moving to HSA regime allows employees the freedom to utilize their HSA balance on any healthcare service of their choice, including items which are excluded under their traditional group insurance cover. Further, with the ownership of funds resting with them, HSAs reduce the propensity of employees to over-utilize healthcare services, which is the case in the traditional third party payor system. This also provides them an incentive to rationalize their demand for healthcare services, since unspent amounts in the HSA allow them to accumulate savings. However, in case of high cost tertiary level medical intervention, they have the fall back option of the catastrophic cover, which provides a safety net.

Though very limited forms of HSAs presently qualify for tax benefits, there is evidence that HSAs are gaining wider acceptance and that HSAs have had the effect of promoting more discreet health spending, without risking employees' health. It has also had an impact of reducing health care costs.

Singapore – Health Savings Account, called Medisave, is a compulsory national health care savings programme that aims to help residents meet their healthcare expenses and to supplement funds drawn from their own savings. Medisave contributions range between 6 and 8 per cent according to the resident's income, and can be used to pay for a variety of specified inpatient and outpatient medical services; both before and after retirement. If money runs short, family members can pool their Medisave balances to pay a hospital bill. Upon death, the resident's Medisave balance goes to his surviving beneficiaries.

Medisave has operated with popular success in Singapore since 1984 as part compulsory, funded, social-insurance system. If a person's account grows to about S$ 30,000, additional contributions are diverted to retirement savings.

Since HSA account balances were not large enough to cover the costs of catastrophic illness, in 1990 the government created the Medishield programme of insurance for catastrophic events. This is neither needs-based nor income-based, and premiums vary with age, but nearly 90% of those eligible opt for it. In addition, the

government also established a Medifund endowment to help provide medical care for those with insufficient means.

China – With rising medical inflation coupled with a growing uninsured population, China in 1994 experimented with the concept of HSA broadly based on the Singapore model of Medisave. The pilot project was initiated in 2 cities namely Zhenjiang and Jiujiang with a combined population of 5 million, representing about 1.4% of China's urban inhabitants. Benefit design consisted of three tiers i.e., HSAs, out-of-pocket spending in the form of deductibles, and social risk pooling. The architecture of this healthcare financing model was based on the premise that HSAs would provide incentives to consumers to be more cost-sensitive in their demand for health services, deductibles would promote cost sharing by patients and social risk pooling would protect persons against catastrophic expenses. The scheme was co-funded by both employees and employers; with employee contribution limited to 1 per cent and employers' contribution to 10 per cent of their total wage bill per annum. From the 11 per cent contribution, 5 per cent was allocated to the social risk-pool while the balance 6 per cent went to the employee individuals and could be used by them to meet their healthcare expenses.

Recognising that controlling healthcare demand alone was not sufficient, the government imposed limits on the use of expensive diagnostic procedures and medications while fixing remuneration rates to providers and other healthcare institutions. The experience of HSAs in China has been rather mixed. While outpatient utilization remained more or less constant and hospital admissions slightly diminished, in some areas, the total health care spending dropped by 24.6% in the year. Resultant savings post implementation of HSA are ascribed to the a combination of inter-related factors such as reduced use of expensive drugs and technology due to the concurrent introduction of a system of fixed charges, cost-sharing with hospitals and high deductibles for patients. The scheme was expanded in 1996 to over 50 cities with an aim to expand it to all urban areas in the future.

South Africa – has its own version of Health Savings Account. After deregulation in 1994, virtually every type of health plan could be sold, and after a favourable ruling from the tax authorities, employer deposits to HSAs received the same favourable tax treatment as employer payment of third-party insurance premiums.

In South Africa, HSA plans have competed against other forms of health insurance ranging from pure indemnity covers to various forms of managed care formats like preferred-provider organizations, health maintenance organisations, etc. The popularity of HSAs can be gauged by the fact that since their launch, HSA plans represent about half the market share of health insurance as against other forms of insurance.

In case of chronic conditions, it is premised that high deductibles may force a patient to economise on regular drugs, eventually leading to health complications and hence expensive care later.

HSA plans in South Africa typically have varying deductibles. For example, a representative plan has no deductible for in-patient care (based on the premise that utilisation of medical services in a hospital are provider driven and that a patient has little scope of control on any overutilisation), as against a high deductible for outpatient care (based on the assertion that patients do have a lot of discretion in negotiating with the physician about the quality, quantity and hence the cost of care).

High deductible also applies to medicines; but not for chronic conditions. In case of chronic conditions, it is premised that high deductibles may force a patient to economise on regular drugs, eventually leading to health complications and hence expensive care later.

Among the more interesting HSA product innovations are screening programmes, with prizes and bonuses to encourage participation, a health information hotline, and electronic verification of HSA balances.

HSA - The Indian Context

Various market researches about health insurance buying patterns suggest that almost all large and medium enterprises in the country provide healthcare benefits to their employees and their dependents, with varying definitions of 'dependents' being applied by the employers. Further, there is no uniformity in types and levels of benefits being provided by employers – coverage is dependent upon the industry type, hierarchical groups within the organization and employee benefit philosophy of the enterprise.

However, in the individual/retail segment of the market, health insurance purchase is age and dependency factor driven. Individuals gravitate towards buying health insurance once they approach middle-age or when their marriage ushers in the need for coverage of the family. Both these triggers are onset by a latent

realization of rising incidence of life-style diseases as well as high cost of medical intervention. For individuals, health insurance purchase decision is also applied as a tax planning tool, since health insurance premiums carry tax exemptions.

While over the years, health insurance has gained acceptance as a healthcare financing tool, it has also erected entry barriers for individuals and senior citizens. This has happened in many ways - arbitrary premium loadings (making it unaffordable to senior citizens), denial of continuity of cover due to age and high claim ratios, and even (in case of certain population segments) low or nil commission to insurance agents which effectively results in the denial of health insurance to that population which needs insurance the most. Further, the psychology pervading the health insurance purchasers makes them 'miserable' about a pure risk cover that provides no benefit for maintaining good health and not claiming for continued policy periods.

Health Savings Account has the potential of addressing many of the shortcomings as mentioned above.

The first HSA type product introduced in the Indian market was 'Bhavishya Arogya' (literally translated as 'Future Health') in 1990 by the public sector non-life insurance companies. The coverage under the policy was similar to Mediclaim, i.e. hospitalisation benefits, but with the difference that the utilisation of benefits was deferred up to the retirement age (vesting age) between 55 and 60 years. An individual could enroll into the policy anytime but with a clear gap of 4 years between the date of joining and the retirement age chosen. The premium contribution could be made either through a single installment or through part installments over a period of time. The basic sum insured was fixed at Rs.50,000/- which could be enhanced by payment of additional premium. The policy did not have any exclusion, not even pre-existing conditions/diseases. The policy could be availed by individuals as well as groups and premium contributions allowed tax rebates. Importantly, the policy also had the provision of withdrawal from the cover with refund of premium before retirement age or post retirement age or in case of death of the policyholder, provided no claim had been preferred.

The products fall short of customer expectations in terms of coverage which is limited to named surgical procedures and a daily hospital cash amount.

The policy was not widely accepted due to lack of aggressive marketing by the insurers and also lack of faith of policyholders about the insurance companies' capability of long-term record keeping since computerization in the insurance industry was just about beginning then. Another reason for 'Bhavishya Arogya' not becoming popular may be healthcare costs not having become a cause of concern for the target segment. Unfortunately, the policy was withdrawn by public sector non-life insurers. No private sector non-life insurer as of now has ventured in this direction.

There have been recent attempts by a few life insurance companies to introduce HSA type products more in the *genre* of unit-linked health insurance. However, the products fall short of customer expectations in terms of coverage which is limited to named surgical procedures and a daily hospital cash amount. Equally importantly, the benefits under the policies cease once the policyholder attains the age of 65 years, after which he is left to fend for himself since at that age non-life health covers become out-of-bounds for him.

A HSA can be positioned in India as a long term health insurance plan, which not only deals with healthcare expenses not covered by traditional health insurance policies, but also related to catastrophic health conditions through a high deductible health insurance policy. It should also aim to provide health security during old age through long term accumulations. In the absence of any public healthcare social security in the country, healthcare expenses during old age is a major cause of concern for the retired persons, both in the organized and the unorganized sector. Increasing attempts of insurers to deny renewals to senior citizens and imposing arbitrary premium loadings impacting affordability have further compounded issues and invited judicial strictures.

There is a growing need for introduction of HSA type product in the country. Introduction of HSA in the Indian market will help deepen health insurance penetration and would offer several advantages over the current insurance system.

- HSAs with ensuing tax benefits are likely to encourage people to start saving early for their old age health expenses since they would have an incentive to accumulate HSA balances. An early entry into the health insurance system would help address the systemic and contentious issue of pre-existing condition exclusions.
- With HSA providing greater discretion to individuals and households on their total healthcare spending, it is

expected that patients would seek greater transparency and efficiency in the medical services accorded to them by healthcare providers eventually rationalizing and reducing healthcare expenses.

- HSAs would provide greater emphasis to the insurance industry towards reviewing the need for providing high-risk, catastrophic policies which will encourage individuals to self-insure for routine medical care. The corresponding reduction in premium costs would allow more individuals, households and employers to purchase health insurance, thus deepening health insurance penetration.
- Learning from the Singapore model of HSA suggests that controlling healthcare demand alone is not sufficient. This should be achieved simultaneously with Government initiatives to implement health sector reforms. The reforms should include development of standard treatment guidelines (STGs), accreditation of different layers of healthcare providers, adoption of DRG (Diagnosis Related Group) and ICD (International Classification of Diseases) coding and quite importantly, the revival of the Indian Medical Council of its original charter for enforcing ethics and professionalism in the medical profession.
- It is necessary that regulatory rigidity should not impede development and growth of HSA in India. The invisible dividing line between the types of health covers life and non-life insurers could ride should not hold back insurers in product innovation. Both life and non-life insurers need to be provided the freedom to develop and market HSA. Life insurers need to broaden their product offering to include all types of hospitalisation as well as increase age of coverage for life-time until HSA balances are exhausted. Similarly, non-life insurers need to develop IT systems that allow them to maintain long-term HSA accounts, HSA being a long-term product.
- It is time the Regulatory Authority recognized health insurance as a separate insurance segment and developed a specific set of regulations for it. With a view to promote long-term health insurance products, including HSA, it is necessary that health insurance business has separate and distinct account reporting, reserving and reinsurance norms. All insurers carrying health insurance business should have health insurance specific revenue accounts, with segregation of management expenses and investment incomes. Further, reserving for health insurance business over one year term should be based on actuarial valuation.
- Since contributions to HSA accounts would be long-term, it may be useful to evaluate the need for a separate limit for tax benefit. A mechanism also needs to be developed for restricting withdrawals from the account for medical services only. Further, unutilised amounts in the HSA should be inheritable on the death of a HSA account holder.
- It is important that HSA accounts are portable so that employees can 'carry' them as they change employers without any disadvantages, probably similar to provident fund accounts. Self-employed individuals or even employees should have the facility to open individual accounts similar to Public Provident Fund accounts managed by insurers.
- Special emphasis should be laid to popularize HSA among the individuals working in the unorganized sector so as to provide them a vehicle for their healthcare financing needs.

It is important that HSA accounts are portable so that employees can 'carry' them as they change employers without any disadvantages, probably similar to provident fund accounts.

The primary argument against HSAs is that they would encourage people to neglect or postpone health problems or physician visits until they would require more expensive emergency or hospital care. However, this has not been empirically established and should not deter the Indian insurance industry to experiment with the idea, whose time has come.

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Health Insurance Data

Enhancing Quality and Analysis

ALAM SINGH AVERS THAT HAVING A WHOLESOME AND DEPENDABLE DATA WAREHOUSE WOULD SET AT REST SEVERAL PROBLEMS ASSOCIATED WITH HEALTH INSURANCE IN INDIA.

The lack of health insurance data in India has been cited by many for a long time. While this would have been true three years ago, that is not the case any more. The data does exist and it is of fair quality. It is also amenable to significant types of analysis. The recently released findings of the IRDA - CII data committee demonstrate this. The committee mainly comprised of professionals from general and life insurance; TPAs and included select representatives from associated fields, such as actuarial, IT, reinsurance, disease management, healthcare and pharmaceutical sector. The findings of this committee were presented at a dissemination workshop on May 9th, 2008. This article explores the way ahead so that the efforts of the data committee are enriched by progressive and meaningful subsequent efforts.

With de-tariffing, the importance of data collection and data analysis for all lines of general insurance has increased significantly. There is now a clear need for more effective utilization of data analysis in the new competitive regime of pricing where cross subsidy across business lines is less feasible. Proper data analysis is also necessitated by new regulations of IRDA such as IBNR (Incurred but not Reported) estimation and Product Filing Requirements. It is also important to create industry-wide benchmarks to enable an insurer to compare its own performance and rates with industry standards. In light of the current scenario, it is worthwhile to look at how data quality can be enhanced, what type of analysis can be conducted, how industry benchmarks can be developed and to understand the benefits of industry collaboration. While most of the concepts presented in this article hold true for all lines of general insurance, this article will only focus on health insurance.

The TAC defined Health Insurance Data Reporting Manual clearly defines health insurance data fields and data reporting requirements. The manual is an evolving document, it will need to keep pace with the changes in the industry by defining additional data elements to reflect product and process evolution. Data fields as presented in the current TAC structure, which includes policy, members and claims datasets, is adequate for many types of the analyses the industry needs. The manual also establishes parameters for improving the quality of the data and that will facilitate more advanced analysis. Since the TPAs did not always have all the data, the onus of providing data has now been shifted to the insurers. The manual also establishes accuracy requirements which the insurers have to achieve. The insurers will need to address some initial challenges to improve data accuracy and completion.

With de-tariffing, the importance of data collection and data analysis for all lines of general insurance has increased significantly.

Although TPA systems do have many common fields, and almost all capture those variables which would be defined as critical, differences still exist and are significant. In addition, as anyone who has had the opportunity to study a large

volume of data from multiple TPAs would testify, the main shortcoming in the data has been adherence to quality parameters during the data capturing stage. Most of these errors can be eliminated easily by introducing validation checks and drop downs in the data entry interface. In addition, education of the data entry staff on the significance of accurate data can easily enhance data quality. A common method for achieving quality is to log who entered which record into the system. Data entry staff are more likely to be careful when they know errors can be tracked back to them.

A high volume of inaccurate data undermines the reliability of any analysis. A lack of reasonability checks, prevalence of duplicate records and inaccurate segregation of expenses into different benefits can significantly undermine the data. In addition, completeness of data is pre-requisite for effective analysis. The variables provided in the data set should be sufficiently populated for accurate analysis. Some examples of common fields which we have observed to have completeness issues are age / date of birth and occupation. In addition, the lack of diagnosis and treatment information is a major hindrance in effective analysis. Frequently, TPAs provided broad level code ranges rather than a unique ICD-10 code. Procedure descriptions or codes, which can be useful to verify the ICD codes assigned to the claims and to populate the ICD codes, are unavailable in many cases. Some of the inconsistencies among the TPAs that I have observed were attributable to a text limit by many of the TPAs' claim processing software. This leads to incomplete diagnosis descriptions. Data in the field can be difficult to comprehend due to syntax errors or broad descriptions such as "Conservative Surgery". Some TPAs provide an additional column titled "Opinion", which frequently contains a combination of a narrative description and procedural information for some records. Occasionally, TPAs do not provide procedure descriptions at all, while others only record drug names. The insurers will need to encourage the TPAs to develop better capabilities in populating these fields and eventually the responsibility for diagnosis coding will need to be transferred to providers.

The demand for quality data from TPAs will increase as the uses of data and its analysis are better understood by all industry stakeholders.

Other fields which need to be represented in a uniform manner by all stakeholders to enhance data usability are: gender, relationship of patient with primary policy holder, unique identifier for hospitals and city names. Some of the fields prescribed in the Data Reporting Manual are not always populated by TPAs. These fields are important from the point of view of data analysis and require more attention. They include; date of intimation to TPA, new / renewal status, pre-hospitalization and post-hospitalization expenses and date of issue of the insurance identification card. The demand for quality data from TPAs will increase as the uses of data and its analysis are better understood by all industry stakeholders. Although awareness about the utility of data in building rating structures, product design and flexible pricing systems has increased, the industry has still not transferred this knowledge to action. Now that TAC has more than 3 years of data, it is time to devote attention to the logical next step - proper warehousing and analysis of data.

Over time data ages and becomes useless, so merely collecting it and storing it serves no real purpose. The logical next step would be to establish a fully functional data warehouse and conduct analysis of this data for the benefit of all industry stakeholders. IRDA should take the lead role in this task as the future role of TAC, in a detariffed environment, is unresolved. With the right tools and skill development, IRDA can easily administer a data warehouse, on behalf of the industry. Current technology enables organizations to implement data warehouses within 3-4 months and at very low costs. The challenge is not one of a viable solution, cost or skills. It is of administrative and internal hurdles. These must be overcome in the larger interests of the industry.

A data warehouse is very different from data which is merely stored in a database. A data warehouse solution has in-built intelligence. The business logic integrated into a data warehouse reflects decades of industry experience. Generally a data warehouse has multiple features and clearly defined operational stages. A data warehouse receives data files in pre-specified format that are then processed for integration into the data warehouse. The processing includes attribute analysis, completeness, uniqueness and business rule compliance test on the data. Then the data is profiled and the extraction

transformation and loading (ETL) routines are executed on the data. The data warehouse engines process the data and insert it into the base repository. Subsequently data marts are created that are subject area specific. The data warehouse decision support system and executive information system uses the data marts and online analytic process (OLAP) cubes to generate structured reports. In addition, it has features that enable the user to drill into the data. Data warehouses are designed for the end user, most of the CXO level reports are available through a dashboard and detailed intelligence can be accessed by a few simple clicks of the computer mouse. Data warehouses deliver actionable information to decision makers. The data warehouse can also be utilized to develop industry benchmarks, to facilitate capture of richer data which enables deeper analytics and to enable status monitoring, in virtually real time. A robust data warehouse can support all lines of general insurance business however in this article we focus only on health.

The data presently available represents a very good data source that could be used by the Regulator and the insurers to conduct their business in a more informed way. Well organized and complete data can yield valuable insights to the industry stakeholders. It can facilitate basic level of analysis, including:

- Assist the regulators and insurance company senior management in evaluating corporate performance.
- Perform most rating and underwriting analyses including experience rating, classification and segmentation analysis and internal tariff development.
- Work with the finance function to evaluate the company's liabilities for financial reporting.
- Work with marketing / sales and underwriting to establish proper pricing for all products.
- Assist the provider contracting function in establishing fair yet competitive fees to pay providers and begin to understand practice pattern differences among providers.

One very important purpose of data analysis is to support the marketing and sales functions by assisting in the development of rates for new products. With a data warehouse this information can be unlocked from an insurer's current book of business. In India, we are imagining first a gradual and then a more radical experimentation with new product designs. At first, such benefits as:

- changes in sum insured
- new floater methods
- inclusion of outpatient or general practice service
- inside caps on payment per day of care, (is already happening by way of room cost limits etc.)
- inside caps on payment by type of case
- inclusion of preventative services
- inclusion of wellness benefits

can be developed by utilizing the currently available data. One limitation that individual industry stakeholders would experience when their analysis is only based on their blocks of business is that their current book of business may not be representative of the customers in the broader national market. Analysis of limited data is susceptible to influences by outliers (data which is at the extreme of the spectrum). A larger data set, based on collective pooling by insurers, would give more insight because it would be statistically credible. If the complete set of health insurance industry data is loaded into a warehouse which all insurers can access for aggregate level analysis, without compromising confidential or competitive information, each insurer would benefit. An industry wide data bank could facilitate the following analysis across the industry:

- Developing benchmark cost for different benefits structure.
- Analyzing the cost differentials across different geographical regions.
- Creating benchmarks for payments to providers for different services.
- Creating benchmarks for claim settlement delay.
- Creating industry-wise development factors to calculate estimated outstanding liability which may be used to help assess the financial health of an insurance company.
- Helping in the assessment and development of solvency guidelines.
- Helping to establish industry-wide cost and utilization trends.
- Exploring the option products and features like MSA (Medical Saving Account), deductibles, co-payment, coinsurance etc. which may not be credible when developed at the individual insurer level.

Pooled data can also be utilized to develop richer rating manuals. These help insurers to establish and maintain rating

Analysis of limited data is susceptible to influences by outliers (data which is at the extreme of the spectrum).

approaches for initial (new business) and renewal (continuing business) rating. When reliable and credible experience data applicable to the group or block of business is available, an actuary is likely to conclude that such experience data is an appropriate basis from which to develop premium rates.

A foundation of high quality and complete data is the basis of all lines of insurance business. No individual company can have data as rich as the industry's collective data sets, so mechanisms of data pooling and sharing can benefit all participants. The ideal way to facilitate pooling is to build a data warehouse to which all participants can have access. The data warehouse can function as the insurer's own dedicated data warehouse (giving them access to all of the data from all the TPAs they interact with) as well a benchmarking platform that provides access to blinded data from all other insurers. The data warehouse can be run as a service to the individual insurers thus reducing the cost of data warehousing for each insurer. With minor safeguards it is very easy to ensure that the data warehouse does not provide access to any confidential information. Identities of the insured, the insurer and other confidential information will not be available to users of the data warehouse. This information can be easily masked. Another major issue which a data warehouse would resolve is the allocation of unique identifier to each policy holder. All credible data warehousing platforms have this capability. It will be a critical mechanism for tracking utilization amongst the insured population over time. Some of the unexpected benefits will include the ability to help the industry understand the long term effect of various forms of treatments for a particular condition and to do long term provider quality analysis. In addition, since the data warehouse also contains the medical information of individual policy holders, it effectively creates a personal health record for each policy holder. This can be very beneficial in the long run for the policy holder.

The industry wide analysis, based on a large pool of data, would yield very useful insights for all the stakeholders. It has often been indicated by existing industry leaders that they oppose pooling as it will benefit newer players more than it may benefit them. This competitive concern is legitimate and needs to be addressed. Data pooling has to be driven by a visible and tangible principle of "Benefit for contributors" (BFC). Contributors who pool data have to be rewarded by access to a significant amount of analytical output that must have tangible business use. In addition, the aggregated data can be utilized to develop industry benchmarks so that contributors can benchmark their own performance against the industry. Participation will benefit all the participants, in the immediate and long term future. Additional benefits of a data warehouse include its ability to function as a repository of denials. The insurance industry deals with two types of denials and it is important to track both. They are denial of coverage upon application or cancellation for cause and claim denial. Denial of coverage data would be shared to ensure that a customer does not misrepresent information to another insurer to obtain coverage.

A common method of tracking this is for the insurers to forward information about coverage denial to a data warehouse which can then be queried by other insurers. Denials must be reported immediately as the customer will seek coverage elsewhere after concealing information which caused the first denial. It is common that denied claims are reported along with approved claims by TPAs. One potential issue which exists is multiple claims by one insured person, with different insurers, for the same claim event. This would be characterized as fraud and is a great threat to the insurance industry in India as it is in other countries. Insurers will not typically write a policy for someone who already holds one because of the potential for moral hazard from over-insurance. That is a person holding two or more policies and actually profiting from a claim event. This is very hard to prevent in the case of cashless treatment without provider collaboration, but is possible to detect in the case of policy-holder filed claims. An effective data warehouse can help identify claims to multiple insurers by a single policy holder and can be used to help detect other potential cases of fraud.

In the initial stages, the data warehouse will require resource allocation which some stakeholders might not be willing to make until its benefits are visible. The incubation period will require sponsorship. However, sponsorship by the industry or Regulator, must be complemented by stern and

Contributors who pool data have to be rewarded by access to a significant amount of analytical output that must have tangible business use.

enforceable directions to obtain industry inputs and compliance in a time bound manner. In other words, the initiative must be designed in such a way that no entity or person can stall or derail its execution. The ideal business model would involve IRDA as the lead agency sponsoring the incubation, a vendor who is willing to build / operate / transfer and an industry that has the foresight to support the initiative and comply with data delivery guidelines in return for actionable intelligence. The vendor must present a model to IRDA based on capacity building for long term management and sustainability. IRDA should be able to recover costs incurred in providing this service thus making it a viable and sustainable service. The cost recovery would be in the form of fees for providing a managed data warehousing services to individual insurers. Availing of a service would enable the insurers to save money as they would not need to invest in hardware, software or manpower. They would just pay a quarterly or annual service charge. Since the data warehouse would be a consolidation point of each insurer's data they would desire to have access to their own consolidated data, analytical reports, benchmark comparisons as well as access to features that enable them to drill into the data. This will assist health insurers in developing provider contracts, rating manuals, underwriting guidelines and service level benchmarks. Access can be rights based and provided by a web interface.

Since the data warehouse would also enable IRDA to perform its regulatory duties more efficiently, it should also be an internal client to the data warehousing initiative. A vendor can be given an incentive to develop a sustainable business model. This incentive could include a share of the revenue that IRDA is able to generate from the rendered services, for a limited period. The vendor must enhance capacity and capability of the data warehouse as the industry grows. The vendor may demand an initial amount as a set up fee or a guaranteed revenue sharing model. Since large amounts of data will require more hardware, system capabilities and staff (analytical & maintenance), IRDA might not want to invest in a system which caters to unpredictable future demands. Therefore it might be desirable to develop a fee model with a vendor which links subsequent payments to the number of covered lives for which data is warehoused. IRDA should have a Service Level Agreement (SLA) with a vendor which should focus on system capabilities and performance. The vendor should be allowed to deploy hardware and systems of his choice, as long as performance exceeds SLA terms. It might be desirable to have this capability built onsite at IRDA. The IRDA staff should receive concurrent training by the vendor. After a certain period the IT system can then be managed by IRDA.

The mid-term goal would be to have a self sustaining service being implemented by IRDA. In the long run, the data warehousing body might become a typical non-profit entity functioning for the industry. Analytical capabilities can be transferred to this entity. The benefits will be visible and quantifiable. Business intelligence delivered by the data warehouse will be useable for product design, pricing and claims management. It will help insurers develop financially sound products. It will also assist the industry in having more harmonious relationships with consumers and judiciary as the data would be very useful in explaining industry actions. Other entities, such as the Ministry of Health and Family Welfare, would also benefit from such a data warehouse as it would give them insight into population disease burden and healthcare utilization patterns. Participation in a data warehousing initiative would be financially beneficial to all stakeholders. That, after all, is perhaps the key yardstick to measure the success of such collective actions.

Availing of a service would enable the insurers to save money as they would not need to invest in hardware, software or manpower.

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Health Insurance Underwriting

Should Insurers Review Their Approach?

G V RAO WRITES THAT IF THE INSURERS DEMONSTRATE A LITTLE MORE POSITIVE APPROACH IN THEIR PRACTICES, HEALTH INSURANCE IS BOUND TO SCALE NEW HEIGHTS.

Health insurance booms

The astonishing growth in health premiums in the last three years is a remarkable feature of the recent developments in the Indian non-life insurance sector. And this phenomenal growth has taken place, despite what is being presently practised by insurers; such as raising premium rates steeply, disputing claims on the ground of pre-existing illnesses, refusing to renew policies on frequent claimers, insisting on equivalent sums insured for each family member that is insured, making portability of health cover difficult etc. What does one make of this paradox that, despite such underwriting restraints, there has been an unabated consumer demand for it?

The health premium, which was about Rs.2,200 crore in 2005/06 rose to Rs.3,200 crore in 2006/07; and it further rose to Rs.4,800 crore in 2007/08. That this growth has happened, in the context of the overall market growth having fallen to 12 percent in 2007/08, from the high growth of 22 percent in the previous year, is another special feature.

The rapid growth in this portfolio in the next few years, it would seem, is almost unstoppable. Health insurance segment is estimated to grow to about 25 percent of the total market of about Rs.45,000 crore in a span of next three years. How should insurers deal with this complex situation? Do they have a corporate marketing and underwriting strategy?

Contrasting market perceptions among insurers

The non-life insurers now seem to have a real dilemma on their hands. A portfolio they had prioritized as low, for their business growth, is booming, as never before. Life insurers, and other standalone health insurers, have come in to field, as new entrants in to this segment, despite its proven past record of ugliness of claims and 100 percent plus losses. What makes this portfolio attractive enough to new players, when the non-life insurers that had transacted it in the past had derided it, as not being good enough for their corporate health? How should they respond to these new market challenges thrust on them?

Life style, hereditary factors and other individualized risk factors do not matter sufficiently to insurers to write this business, as exclusively individualized. Homogeneity of risk group for rating is based on age; and it continues to be so.

Health insurance premiums of Rs.4,800 crore in 2007/08 constitute about 17 percent (up from 13%) of the total market of about Rs.28,000 crore. It ranks as the second biggest portfolio in the Indian market, next only to motor that forms about 45 percent. What has caused the upsurge of public interest in health insurance from the buyers?

A few basic issues of concern

Age-band to which an insured belongs alone is the current underwriting consideration to quote a premium rate. Life style, hereditary factors and other individualized risk factors do not matter sufficiently to insurers to write this business, as exclusively individualized. Homogeneity of risk group for rating is based on age; and it continues to be so. It has not evolved over the years due to their inability to collect experience data. Risk discrimination within the age group is not made. That is a major issue for insurers.

Each insured in the health segment is a unique risk irrespective of his/her age

The ripple effect of the growing Indian economy is seen in the rapid rise in the number of persons buying health insurance covers, for themselves and their dependents; ahead of even considering their buying life insurance covers.

and that is why in health insurance, underwriting and pricing risk factors properly is even more important than in any other segment of business. There are no risk management measures an insurer can possibly suggest on the life style of an insured, nor can there be an audit of what precautionary measures for wellness an insured takes on his own. The point made herein is that careful underwriting has a major impact on expected outcomes; more on this later.

What this article addresses

The article seeks to address a few of the issues, which non-life insurers have presumably missed out till now. They need to change their business behavior, as health insurance has always been a loss-making portfolio, under free pricing regime; and hence it has always been more amenable to improved product design and rating, superior underwriting standards and innovative claims handling. What has caused the sudden upsurge in demand?

Why this sudden upsurge?

The ripple effect of the growing Indian economy is seen in the rapid rise in the number of persons buying health insurance covers, for themselves and their dependents; ahead of even considering their buying life insurance covers. It is as though there is a race running between buying life insurance and buying medical insurance covers, and as to which of the two is a better primary protection for the income-earning younger population, and the ever expanding health conscious retirees and the oldies.

Another reason is the deployment of life insurers into the health insurance field, and the emergence of new stand-alone non-life insurers that have considered health insurance business, as a commercially feasible proposition for them to enter this exclusive domain. The IRDA's insistence on each of the life and non-life insurers to have a minimum premium from rural businesses and persons, has set the scene for fuelling further growth in the rural health insurance business. How do current insurers view and evaluate this emerging situation?

Attitude of non-life insurers

It is a pity that non-life insurers, who pioneered the individual health insurance cover, have not been able to come to grips with the technical and managerial intricacies of handling this galloping health portfolio. When that happens, as it must, there would be another growth trajectory. Their current passive attitude of merely providing a cover must change into fuelling a growing demand for it.

The containment of claims cost is their biggest challenge. And with the right mix of product design and an alignment of interests between them and the service providers, it should be possible to write the business profitably. Insurers today, voluntarily, have relegated themselves, as passive paymasters, with no role in the claims process and with no customer and medical data available with them. In the current system, there is no scope for their learning the business intricacies involved.

Peculiarities of premiums-claims data

One peculiar feature of the health insurance business transacted, till now, is its unusual criterion of low frequency of claims at about 6 percent, while the average severity of claims is disproportionately high at about Rs 22,000 (average premium per individual is about Rs 2000) resulting in the claim ratio of 110 percent for insurers. A few claimants, of about 6 out of 100, are cornering the total premiums paid by the 100. An unanalyzed majority are just premium payers. Insurers have not been able to capture the characteristics of the large silent premium payers and the minority claimants.

The evidential data cited above can be extracted in detail from the statistics put out by the Tariff Advisory Committee on its website. It is rather surprising that though the TAC has put this information on its website, it is not known to many staff of the insurers, and much less has the information been analyzed for understanding the trends. Insurers need to analyze the data before making assumptions that forms the basis of policy making and business strategy.

Insurers are now confronted with a situation in which they are losing money, on a portfolio that is set to grow even faster, and is likely to become even more competitive, and perhaps profitable under revised circumstances of new product design and stricter underwriting criteria.

Do insurers understand market dynamics of health insurance?

Insurers have regarded underwriting health insurance business, as akin to underwriting personal accident or

homeowners insurance covers. Even these covers are just accepted but not underwritten. Following detariffing, insurers have discovered that they have yet to learn the art of underwriting even basic risks in fire and engineering. To expect them to do medical underwriting skillfully is too much for any one to expect. Insurers must know their current underwriting limitations and start learning to do professional underwriting through acquiring the expertise needed.

Secondly, insurers should go beyond their current role of offering financial protection against health risks. They must get involved in the selection of the service provider, in the nature of treatment necessary and prevent excessive usage of medical services either by the insured or by the service provider, who has a natural tendency and incentive to do so.

The current mindset of routine medical underwriting has debilitated insurers, from understanding the market dynamics of how health insurance business operates. Insurers have currently little control on claims processing that is now determined by the insured claimants and the service providers; one is interested in complete cure and the other in the usage of its medical services available. In most cases, the upper policy limits operate as service provider's minimum ceilings on claims, with little financial pain for either.

This dynamic has to change perhaps by making the claimants, as co-insurers and involving them as joint insurers, at reduced premiums. The silent majority of premium payers - but not the minority claimants - would second the move. The informational asymmetry in health transactions among the insured, the provider and insurer is rather wide. The value chain is driven by the health care provider, and realized by the insured patient, but at the cost of insurers. The medical management of treatments given to a patient is not standardized; and hence it is subject to supply-induced excessive medical services. Insurers' inability to influence clinical decisions of the service provider is another factor of asymmetry.

Patients, once they are insured, demand the best of medical services that medical technology can provide them (ex-post moral hazard) once they need medical attention. Within the hospital the numerous medical treatment agencies try to gather medical information afresh, as the patient is passed on from one medical services' supplier to another, raising costs of treatment, on one single patient. Multiple-decision making processes at the service provider's place causes inefficiencies and high costs.

While insurers are subject to statutory regulation, the other links in the health care delivery chain like the service providers, the suppliers of medicines and its distributors are not. This makes accountability of these links more diffused. These issues need to be addressed. Insurers must devise innovative means to tackle these challenges, with the twin objective of quality patient care and the containment of claims costs.

Medical management, without sacrificing a patient's health care treatment, and without affecting the clinical freedom of service providers has to be learnt and practiced at one level.

Insurers should stop regarding themselves as victims of a sophisticated group of customers out to fleece them of their profits of the health insurance business. How to make both the insured and the insurers, as winners of their mutual transactions, is the sole responsibility of insurers, who lay down all the norms in the customer recruitment program of theirs. What aids are available to them

What aids are available for loss control?

Insurers are expected to align the interests of the service providers, the insured and their own to establish best practices and arrange for high quality treatment for an insured patient. Medical management, without sacrificing a patient's health care treatment, and without affecting the clinical freedom of service providers has to be learnt and practiced at one level. The current involvement of insurers in this process is nil.

The second is to use the tools of product design, benefits covered, rates, renewal terms, deductibles, co-payments and reimbursements to influence the behavior of both the service providers and the insured. Underwriting is the stage where the selection of the insured, the product benefits, the pricing structure, claims processing, selection of service provider and the sharing of claim amounts between the two must be determined.

If these tools are not used, one should not blame the insured. Medical underwriting is not akin to underwriting fire and marine risks. It is at the stage of recruitment of customers that insurers should exercise all the underwriting care they think would benefit both. If the process of recruitment of customers is made easy and automatic, insurers cannot obviously blame customers, as they do now.

As always, underwriting is the key, as there are no clearly defined homogeneous groups for rating; the age-band grouping used should be modified, based on each insurer's perceptions of

Every contributor in the value chain must be milked for concessions to reduce the claims costs that make the premiums less unaffordable.

risk factors to be identified for loadings and discounts. Claim settlement agreements should be determined at acceptance stage. Hence health insurance underwriters should be separately trained.

The choice of the selection of the service provider may be left to an insured, while influencing and determining the benefit packages available at such selected service providers, which should be done by the insurers. The present practice of the choice being left solely to insured, without his having to pay for his selection is a reason why the insured goes for the most expensive hospital. Premiums have to be differentiated depending on the choice of service provider made by the claimant.

Insurers must negotiate the medical treatment charges on a preferential basis with the service provider, in return for its patronage. The clinical freedom available to doctors must be allowed to be exercised with more care and deliberation. Insurers must be seen as watching the process to ensure that this does happen. With more claim monies flowing to service providers, time has now come for insurers to exercise their choice in the selection of the right and trusted service providers and to negotiate smart remuneration schemes to align mutual interests.

Insurers must also engage with the manufacturers of medicines to give them discounted rates on proof of consumption of their products, even post-consumption. Every contributor in the value chain must be milked for concessions to reduce the claims costs that make the premiums less unaffordable. It requires an eagle eye to spot opportunities for such concessions. Self-interest guides the health transaction; and if insurers through their lethargy want to miss out on saving costs, they have only themselves to blame.

Insurers should collect, analyze and interpret data to improve pricing, risk management and governance, as a part of their administrative process. To increase efficiency, insurers should consider implementing standardized disease treatment and procedure coding. 'Case management' that is avoidance of the excessive use of same tests by different wings of the same service provider for diagnosis is an issue before insurers for resolution. "Disease management"—treatment of chronic diseases of patients for alleviation, and not cure, is another issue before insurers to resolve.

What can the Govt. do to stimulate growth?

In the Middle Eastern countries, it is mandatory for all employers to meet the healthcare costs of their employees. The Indian Govt. that is interested in providing healthcare provision for its citizens must make it mandatory for all the listed companies in the Stock Exchange to provide all their employees a mandated healthcare provision, whether it be by insurance or just meeting the medical costs of an employee, as long as he/she is employed by the employer. This single measure would boost demand for health insurance making reduction in premiums, a distinct possibility. It is for the 40 odd insurers in the market to lobby for it.

Secondly these insurers must also lobby, year after year, for waiver of service taxes of 12.36% on health premiums, as it is unfair for a Govt. that swears the best interests of its citizens as guiding its heart, to financially benefit out of the self-induced desire of its citizens to seek a healthy life, without any Govt. intervention and support. The consumers are not organized; hence it is for insurers to take their cause.

Final word

No non-life insurer can shy away from transacting health insurance business, when more and more insurance providers are entering this field. It has gained an unstoppable momentum of its own. It is a portfolio that would also lead to creation of greater insurance awareness of other insurance covers. It is retail, and not corporate health insurance, we are referring to. It is necessary to sail on the wave of demand for health covers that is consumer-driven. Insurers have to learn to adapt to the emerging market realities.

But to write it profitably, insurers would need to understand their health business intricacies better; and they must create a value chain of quality patient care, a service provider that is more professional than commercial and impose underwriting standards that lessen customer moral hazard and keep the health insurance rates affordable to the largest majority. Involving customers in claims negotiation with service providers through deductibles and co-payments would eradicate numerous moral hazard issues.

Insurers must also make products affordable, acceptable and accessible to rural folk. A partial indemnity at affordable rates—just like the Janata Personal accident cover—is the urgent need of the rural folk. Insurers have to approach their business potential more innovatively and more aggressively, and come out of their passive roles as mere insurance providers, responding to demands made on them. They should create the demand for their products and services. Is this too big a challenge for them? Not for all the insurers, the writer hopes.

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Developing **Sustainable Health Insurance** in India

Learning from International Experiences

R. KRISHNAMURTHY AND GAYLE ADAMS EXAMINE THE KEY ACTUARIAL AND BUSINESS PRACTICES IN THE BUOYANT HEALTH INSURANCE SECTOR.

A mild explosion in the Indian health insurance market has begun since the time IRDA announced three major policy changes about three years ago, sending strong signals about the 'development' role of the regulatory body.

First, the recommendations of the committee set up by IRDA to examine the status of health insurance had strongly favoured a set of regulations governing this segment, along with a call for lower capital and solvency requirements.

Second, faced with the slow start of specialized health insurers, and with a view to promoting competition among existing players, the regulator has allowed life insurers to offer pure health insurance products without death benefit cover. This is a major departure leading to life insurers who were offering scores of health riders, often highly priced and poorly sold, to actively look at the health insurance segment.

Third, the regulator has opened a major opportunity for stand alone health insurers in the area of distribution. Health insurance companies are allowed to engage the services of agents licensed for life or non-life distribution in addition to building their own feet on street, thus enabling a new generation of health insurers to widely exploit the distribution channels to offer affordable health insurance products to all segments of population.

With the above changes and the additional tax-supported incentives announced recently, health insurance has become an industry buzz word. There has been a proliferation in both products and the suppliers, accompanied by rapid premium growth, leading to huge (and sometimes fancy) expectations in the period ahead.

Indian health funders and providers have now a valuable opportunity to achieve the 'leap frog effect'. What the health insurance market in India will look like in the next 10 to 20 years depends very much on the evolution over the next 5 years. Sensible actions now can mean that there can be a thriving, successful, high quality health delivery and financing market that is a significant societal asset as well as a source of good business opportunities. Conversely, poor choices now can lead to a smaller disgruntled insurance market, unviable products and a distorted and inefficient health care system.

Current status

Insurers in India have generally sought to adopt overseas product features and management practices. However successful evolution requires more than this. This is partly because each health care market has unique characteristics and drivers, and most countries do not perform all aspects of health insurance well.

Sensible actions now can mean that there can be a thriving, successful, high quality health delivery and financing market that is a significant societal asset as well as a source of good business opportunities.

Many overseas insurance practices reflect the insurers' unique history, legacy issues as well as specific regulatory restrictions and value systems of the country. Even within small, relatively homogeneous countries with fairly common products and practices; there are wide variations in medical indemnity experience and attitudes between regions. Also the underpinning health delivery system is itself undergoing fundamental evolution.

The 'new' insurance products that are on offer in India are across the continuum from indemnity medical insurance for specific expenses with relatively small frequent benefits such as Medicaid, to lifestyle/income support products for specific infrequent conditions such as with critical illness or disability income products. Many products and associated initiatives have been based on overseas practices with varying degrees of success.

The degree of senior management attention in most Indian insurance companies in the matter of health insurance products and their inherent skills and expertise differ significantly. This has led to a wide variety of practices, standards and product features even within relatively similar product groupings. As what might be expected in such a young and diverse market, the soundness and competency of implementation and management of these initiatives has been variable; reflecting the different core competencies, experience, internal skills and resources.

The rush to diversify into personal lines of health insurance and offer innovative features by most players has resulted in some teething problems and tensions between different stakeholders. Examples are the increasing market unrest as insureds find unexpectedly that their existing conditions are not covered, the 50% lapse rate noticed on some health riders, and pressure for insurers to offer long term rate guarantees on products where claim frequency can be expected to vary unpredictably, usually increasing, with the development of the health system.

The rush to diversify into personal lines of health insurance and offer innovative features by most players has resulted in some teething problems and tensions between different stakeholders.

Key risk management issues

With a large range of products that are considered health insurance, it is worth conceptualizing a framework within which to consider them. One framework is to consider the purpose of the product such as whether the benefit is intended to cover (i) a specific type of expense (targeted small frequent benefits) or to (ii) more generally provide income/ lifestyle support (untargeted large infrequent benefits).

The form with which the benefit is paid can also be a useful division, for example whether lump sum (critical illness, medical indemnity) or annuity (disability income, some hospital cash products). Benefit purpose and type have a significant impact on product management from underwriting, distribution and claims management. The features and management of products towards the indemnity end of the spectrum are significantly different from those at the lifestyle/income support end of the spectrum.

From an actuarial management perspective, there are several important differences between the medical indemnity and disability income ends of the spectrum that impact product management. These include:

- *The concept of an insured event:* This is less clear and can change implicitly over time, comparable to a changing "basket of goods".

  For example, over time the proportion of x-rays and open heart surgeries reduce, while MRI's and angiograms increase. This is unlike motor insurance where a stolen radio cassette player does not get replaced with a state of the art DVD sound system. In life insurance, the concept of death is fairly well defined!

  This happens even when underlying morbidity claims experience is stable because benefits depend on medical practice patterns that change over time and is to some extent influenced by provider supply and availability. New treatments are regularly introduced and increases in private healthcare capacity change the frequency of insured events, such as increases in the number of bed days per insured population.
- *An often volatile and significant claims escalation trend:* Life insurance experience tends to slowly improve over time while hospital and medical insurance based products are often subject to large, rapid changes in experience. Claims can increase by more than 15% in a year and long periods of sustained increases have occurred in many countries.

  The claims trend is only partly influenced by inflation and even health cost inflation. This can make it difficult for policyholders to understand the need for rate increases, often causing

the public perception that insurers are profit mongering.

This volatility has significant implications on product design and customer communication. Insurers need to be careful on premium guarantees that they may be prepared to offer. Product profitability needs to be reviewed at least annually, and sometimes quarterly, and efficient internal systems such as premium rate increase processes are required to react to deteriorating experience in a customer friendly manner.

Where there are premium guarantees, considerable care is required when assessing the longer term down side risk, the implications on the required capital for solvency and appropriate return to shareholders. In other markets, insurers have sometimes made significant losses by offering premium guarantees and then incurring unanticipated high levels of claim escalation.

- *Some customer discretion about whether an insured event will actually occur.* The mere fact that a customer takes out a medical indemnity policy can increase the chance that an insured event will occur. This is because reimbursements are based on occurrence of medical expenses and not the occurrence of morbidity. A customer suffering pain may choose to get an expensive procedure if the cost is covered by insurance while they may not if they need to lose their family savings to fund the procedure. A customer is unlikely to die earlier because they take out a life insurance policy (self harm and poor underwriting aside).
- *High volume of small claims*. The different size and frequency of medical indemnity claims has significant implications for product management, especially for claims, actuarial and operations. The organisation needs to have extremely efficient and timely back office claim payment systems. Smaller claim sizes often mean that there can be delays of several months before insureds submit their claims. This makes it important that actuaries use appropriately sophisticated techniques in calculating outstanding claim estimates or risk making unexpected losses or undercharging premiums.

  Slow claim turnaround times results in poor customer satisfaction, bad press and even damaging rumours about the insurer's financial condition. Conversely good claims service is often a major point of competition.
- *Less knowledge of impact on claims costs of particular risk factors*. For example, there is much knowledge about the impact of high blood pressure on mortality but much less on what and when the impact will be on medical costs. Also relatively trivial conditions like asthma may have negligible impact on mortality but the cost of annual maintenance medication can be a significant proportion of the health insurance premium.

  Because of this, insurers often rely heavily on exclusions as opposed to premium loadings when allowing for differences in risk profiles. Care needs to be taken that there is not an over reliance on overseas underwriting manuals because the impact of particular conditions can be very different between countries.

  Life insurance companies venturing into health insurance segment would appreciate that some aspects of life underwriting are unsustainable where there is a greater reliance on self disclosure, claim validation, product level exclusions and waiting periods. In health insurance, the insurer is more exposed to asymmetrical knowledge about the risk.
- *Data requirement to properly manage health business is extensive and detailed*. Population data is less relevant to insured experience and morbidity is only one of the claim drivers, with medical practices often being a more significant driver of claims experience. The extent of preparations for data capture and analytical capabilities are raw in most new companies. Trend analysis in health insurance is more complex and experience harder to understand.

Care needs to be taken that there is not an over reliance on overseas underwriting manuals because the impact of particular conditions can be very different between countries.

India needs customer-friendly products

Like all forms of insurance, it is essential for basics to be performed well in the health insurance segment. Basics that require special emphasis include sound product design, efficient and fair claims management, appropriate distribution, strong actuarial and financial control and effective underwriting.

Fundamentally, India needs simplicity of concept in product design with benefits that are clearly understandable by policyholders. A major source of customer discontent, poor press and cause of adverse regulation in various markets is caused by customers not understanding the scope of benefits

under medical insurance cover. Though not a direct parallel, one is tempted to draw a comparison to the evolution and growth of unit-linked investment schemes in India during the last few years with a complex array of products and designs which few policyholders understand clearly, with regular reports of mis-selling and poor customer management. There is a need not to make this 'mistake' in the new health insurance segment.

Companies should seek to describe the practical implications of the cover in a sentence or two of simple English (and in vernacular languages) and not allow them to be hidden behind a myriad of inside limits or obscure medical terminology.

It is important for both claim control and society that product design encourages sensible medical practices and utilization. Well designed risk sharing features such as co-pays, excesses and co-shares are obvious valuable and sound tools. Profit sharing arrangements with provider groups can also be useful in obtaining efficiencies. In these situations, it is best if insurers work constructively with providers as partners with the intention of achieving best efficient practice.

Relevance of wellness-based initiatives

At the early stage of health insurance market, Indian insurers should design products that encourage sensible health care delivery and, where possible prevention.

The concept of building prevention or wellness features into products is attractive intuitively both from marketing and claims experience view points. There has been much discussion in overseas markets about various forms of wellness initiatives that expand basic health insurance cover. These range from health screening, annual health checks, disease management programs and medical savings accounts.

The insurer should check that expected savings in future claims from better health will be generated over a reasonably short period.

It is relevant that the wellness initiatives in mature overseas markets are driven by a variety of reasons such as:

- Desire to reduce premiums by reducing claims costs
- Respond to policyholders' desire to make use of their policy even if not sick, or to be rewarded for their perceived better health risk or lifestyle
- As a clever marketing hook to promote product sales
- To improve the insurers' public image by seeming to be 'caring'.

Some initiatives have been universally successful and others not so successful. The underlying reasons are varied and may not always apply in the Indian context. The more complex initiatives such as disease management programs have generally been introduced in mature markets.

From an actuarial angle, insurers should consider the cost and expertise required to manage a wellness program in the basic insurance product. It is relatively cheap and easy to introduce features such as an annual medical check up, or offer of discount to reward low claims. At the same time, wellness initiatives designed to serve as long term risk mitigation tools can be difficult to implement, requiring considerable development resources, as for example, establishing and managing an effective evidence-based cardiac care program.

It is important to assess the net effect of the impact of such initiative on risk premium, new business volume, customer retention and claims cost. The key question is, does the benefit of introducing the wellness program justify potential use of limited internal development and management resources, and whether the business reason for introducing the initiative is purely marketing, or lowering the premiums or increasing the profits.

There is also a potential risk in wellness programs that they might unexpectedly bring forward or otherwise increase medical expenses, especially in the short term. The insurer should check that expected savings in future claims from better health will be generated over a reasonably short period. For example, two common types of disease management initiatives that provide a service of chronic illnesses are asthma and heart disease. Experience in other countries has shown that some heart disease programs can take 10 years for future savings to cover the costs of initial investment, while some asthma programs have been shown to break even within two years.

Some insurers have used a low or no claims discount as a pragmatic approach to addressing a common policyholder desire to get "value" from their policy as a reward for being healthy and not claiming over more complex initiatives.

Medical saving accounts

Medical savings accounts as a wellness based initiative have been introduced in several countries with varying degree of success. The principle is sound and is generally a popular concept with potential insureds.

In the Indian context, there is also a considerable need to educate the public on the benefits of health insurance, as well as on the responsibilities on the part of insured customers.

Most of the countries that have had success with these products have generally provided tax advantages or other government support. Medical savings accounts have been successful in both Singapore and the USA where there are tax or other government concessions, while in New Zealand there is no explicit government support and medical savings accounts have failed to achieve significant volumes despite market research showing that it would sell strongly. One reason for the disappointing New Zealand performance is that policyholders were finding the basic health insurance premium difficult to afford, and so were not able to make additional payments to help fund the longer term savings component of the product.

Regulatory canvas

At a time when IRDA is working actively to draw a set of regulations to govern the health insurance activity, it may be relevant to visit the experiences of key countries.

A key message in health insurance regulation in developed markets is that this is not the sole prerogative of insurance regulator, but as part of a comprehensive architecture that exercises oversight on medical practices, treatment procedures, and intermediary service providers. There is an acute need for coordinated action in this regard in India. A well thought out programme of accrediting hospitals initiated sometime ago is slow to make headway, which might help introduce simple health insurance products tailored to different economic segments of population linked to their paying capacity.

The regulatory practices should also need to recognize that at the early stage of market development, a sustainable way to grow business is to ensure the viability of the business line, with enough flexibility to insurers to re-price the products based on experience.

Experience in other countries has shown that the need to maintain or increase market share has sometimes caused insurers to offer unviable product features. In a rapidly growing market such as India, these pressures should be much easier to resist.

Some poor practices have crept in because health insurance was a minor and yet profitable part of the insurer's overall business, meaning that normal insurance controls and internal expertise and resources have been used for the 'core' businesses, but not to the health insurance segment to an adequate extent. Some of these insurers have then been caught unprepared when experience deteriorates after the health insurance portfolio has considerably increased in size and significance.

In some markets, insurers are known to have suffered large losses in health insurance for avoidable reasons. For example, insurers' losses have sometimes stemmed from charging unintentionally inadequate premiums simply because they did not allow for the longer IBNR tail or monitor their experience frequently enough to detect a rapidly increasing claims trend.

The consequences have been volatile returns for insurers, some unsound and potentially long term uninsurable products, uncertainty for insureds and undesirable distortions in the actual health delivery system. Insurers' insensitivity to public expectations has also sometimes led to public backlash, knee jerk legislation as regulators try to take rapid action to prevent undesirable and unnecessary practices, leading to an adversarial relationship between insurers, providers and regulators. These consequences have quite possibly led to reduced overall size of the market with unnecessary restrictions on innovation and reduced opportunities for business.

In the Indian context, there is also a considerable need to educate the public on the benefits of health insurance, as well as on the responsibilities on the part of insured customers. For example, due to customers providing inadequate information for insurers, there have been several instances of service delays and dissatisfaction with customers being unaware that certain conditions are not covered until the time of claim submission. Sound sales practices and agent training play an important role.

To sum up, India has the great opportunity to spearhead a viable and competitive health insurance sector and encourage the development of a sound high quality health delivery system. What is required is a good understanding of the actuarial and other risks in the business, a long term vision for those entering it, simple product design, supportive regulation, and sustained customer education.

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• प्रकाशक का संदेश

एक ऐसे देश में जहॉ हैल्थ केयर पर अधिकांश खर्च जेब से बाहर के द्वारा खर्च किया जाता है सबसे संतुष्ट करने वाली बात हैल्थ बीमा संविभाग में त्वरित वृद्धि है और यह वही है जो भारतीय परिवेश में हो रहा है। इस वर्ष समाप्त हुए वित्तिय वर्ष के आंकड़े पिछले वर्ष की अपेक्षा 60 प्रतिशत की वृद्धि बताते हैं और इस बात को ध्यान में रखते हुए की हैल्थ संविभाग बिल्कुल शावक है इसकी सार्थकता दुगनी हो जाती हैं। वृद्धि बड़ी मात्रा में यह बताती है कि कैसे बीमा कर्ता इस बीमावर्ग को प्रोत्साहित कर रहे हैं। जहॉ तक हैल्थ बीमा का प्रश्न है यह भी तथ्य का साक्ष्य है कि मौन रूप से लोगों में इसकी समझ बढ़ी है। यह सभी तर्क उस अर्थव्यवस्था के लिए बहुत अच्छे हैं जहाँ हैल्थ कैयर पर पैठ एक दूर का सपना लाखों के लिए है।

उसी प्रकार, सभी जटिलताएं जो इससे जुड़ी है वह सभी इस प्रकार सुलझ गई है। इस प्रक्षेत्र में कुछ बुराईयों वह लगातार बनी हुई है तथा तथ्य यह है कि हैल्थ बीमा नये स्वरूप में ग्राहक की शिकायतें लायेगा अन्य कारकों की अपेक्षा विशेष रूप से वरिष्ठ नागरिकों के लिए हैल्थ बीमा उपलब्ध करवाना वह भी सहन योग्य प्रिमियम पर वह एक क्षेत्र है जो प्रसिद्धि लिए हुए है और जब तक बीमा उद्योग इसका सामना नहीं करेगा पहले की अवस्था में ही यह संभव है कि यह उद्देलित हो जाए एक विवाद के रूप में। यदि प्रिमियम दरों में तथा पहले से रहने वाली बीमारियों पर स्पष्टता प्राप्त कर ली जाए तो यह आशा की जा सकती है कि इस प्रक्षेत्र से जुड़ी कई बुरी बातों को विराम दिया जा सकेगा।

पालसी धारक को बीमा संविदा के मूल गुथी को समझना चाहिये जिससे वह दावे के विवरण की जटिलताओं को समझ सके। एक बीमा को खरीदने के लिए उसका भुगतान आपदा के साथ बीमाकर्ता को धोखा देने से कम नहीं होगा, वैसे यह करना सरल नहीं है जो कि युक्तियुक्त प्रतीत होता है। वैसे बीमा जागरूकता के स्तर को बढ़ाना साधारण जनता के बीच मददगार साबित हो उन समस्याओं के लिए काफी हद तक।

इस अंक के केन्द्र बिन्दु में दुबारा "हैल्थ बीमा'' है। एक संविदा में कुछ वर्षों तक रहने के बाद लिए प्रिमियम देने की प्रतिबद्धता को न निभाना किसी के लिए भी लाभ नहीं की स्थिति को उत्पन्न करता है। जर्नल के अगले अंक के केन्द्र बिन्दु में जीवन बीमा संविदा का कालित होना होगा।

जे. हरि नारायण

जे. हरि नारायण
अध्यक्ष

दृष्टि कोण

बीमांकक इसके लिए उत्तरदायी है कि यह सुनिश्चित किया जाए की बीमाकर्ता के दायित्वों का मूल्यांकन किया गया है, मजबूत बीमांकक सिद्धान्तों के आधार पर जिससे बीमाकर्ता को पर्याप्त संपति अपने दायित्वों को पुरा करने के मिले यदि आवश्यकता हो।

श्री लो क्को मुन
कार्यकारी निदेशक (बीमा पर्यवेक्षण) सिंगपुर की मोनेटेरी एथोरिटी

प्रगतिशील हैल्थ बीमा कार्यक्रम न केवल समय पर वहन योग्य गरीब गृहस्थों को सुविधा प्रदान करता है वरन् वह उन्हें वित्तिय महाविपदो के हैल्थ स्पर्थों से भी बचाता है।

श्री जार्ज दिखुन
मिशन निदेशक, यू एस ए आई डी, इंडिया

आई आर डी ए को अग्रसक्रिय कदम उठाने होगे उपयोक्ता के मध्य जागरुकता फैलाने के लिए की वे जो सूचना चालते है तथा उन्हें क्या प्रश्न बीमा योजनाओं के बारे में पूछने चाहिये।

श्री सी एस राव
पूर्व अध्यक्ष, बीमा विनियामक विकास प्राधिकरण, भारत

विश्व के सबसे बडे बीमा बाजार के लिए संयुक्त राज्य एक प्रतिमान के रूप में विकासशील बाजारों के लिए है, साथ साथ अन्तराष्ट्रीय मानक बीमा विनिमयन के जिनसे अन्तराष्ट्रीय मानक विकसित हो सके।

श्री वाल्टर बैल
अल्बामा बीमा कमीशनर, तथा अध्यक्ष एन ए आई सी
अन्तराष्ट्रीय बीमा सम्बन्ध समिति

बलवान प्रबन्ध में विरोध के प्रति अपेक्षाएं अधिक होगी जहां भावी प्रभावित दल अलाभ की स्थिति में देखने जायेगे जिसका कारण सुचना असमामिति है जहां एक दल सम्बन्धित मुद्दों को अपने हाथ में रखाता है दूसरों की अपेक्षा।

डा रमनी वेंकटमनि
महा प्रबन्धक आस्ट्रेलिया प्रुडेशल रेगलेशन एथोरिटी

कोर बैंक के बनाने में मुख्य निर्माण रुकावट मजबूत पूंजी है। मजबूत तरल दाबडा, मजबूत जोखिम प्रबन्ध तथा पर्यवेक्षण तथा बेहतर बाजार अनुशासन पारदर्शता के माध्यम से।

श्री नाऊट वैल्लींक
अध्यक्ष,बैंकिंग पर्यवेक्षण की बैसल समिति

बीमा बेचने में सदाचार - उत्पादों की सुसंगता

डेविड चन्द्रशेखर कहते हैं कि सदाचार विक्रय में उत्पाद की सुसंगता पहला कदम है। वह आगे कहते हैं कि यह सुनना सरल लगता है यह करना कठिन है उन सब कारकों को ध्यान में रखते हुए जो किसी विक्रय के लिए होते हैं।

बीमा के लोगों में उत्पाद की सुसंगता सदैव ही वाद विवाद का विषय रहा है। इस विषय पर इतनी बात होने की एक वजह यह है कि यह सुनिश्चित किया जाए की बीमा विक्रय सुसंगत हो। प्राकृतिक रुप से जो प्रश्न इस सम्बन्ध में सामने आते है वह अधोलिखित है। क्या बीमा बाजार में किया जाने वाला विक्रय मोटे तौर पर सुसंगतपूर्ण है? क्या बीमा बाजार के खुलने के बाद इसमे कोई परिवर्तन आया है? और उससे अधिक मूल प्रश्न क्या कैसे भी बीमा की सुसंगतापूर्ण विक्रय संभव है? अन्य शब्दों में क्या गैर सुसंगत प्रथाओं का सहारा लिए जैसे झूठे प्रक्थन तथा अर्ध सत्य तथा मौलिक तत्वों को प्रकट न करना जिसमें पालसी में क्या कया आवरण प्राप्त होगा जोकि होता नहीं है?

बीमा में सुसंगत विक्रय के मुख्य मुहे कि सरहाना करते हुए किसी को भी बीमा का आधारभूत सिद्धान्त देखना होगा वह है सद्भाव का सिद्धान्त पाठक यह देखेगा की यह प्रयोग की गई भाषा बहुत संक्षिप्त तथा मुख्य है। केबल परम सदभाव ही काफी नहीं है यह परम सद्भाव होना चाबिये। इस सिद्धान्त को बीमा कर्ता तथा बीमाकृत पर समान रूप से लागु किया जाना चाहिये। न्यायालय के निर्णय ने भी इसकी पुष्टि की है कि परम सद्भाव का सिद्धान्त की कर्तव्य बीमाकर्ता के लिए परम सद्भाव कर सिद्धान्त ने केवल आवश्यक आता है यह उत्पाद विक्रय सुसंगता के लिए एक आधार बिन्दु भी है।

व्यवहारिक रूप से एक एजेंट के लिए इसका अर्थ बहुत सरल है: उन्हें एक शपथ लेनी चाहिये और उसे शब्द तथा भावना में निक्रय प्रक्रिया में अपना चाहिये सच कहने के लिए केवल सच कहने के और कुछ नहीं उत्पादों के लाभों को स्पष्ट करने के लिए इन लाभों को प्राप्त करने के लिए तथा अपजनों को पूरा करने के लिए। इसके लिए एजेंट द्वारा एक सिद्धान्त का अनुसरण एजेंट द्वारा किया जाता है तथा अपर्वजन क्या होगा। यदि यह सिद्धान्त एजेंट द्वारा अपनाया जाए अन्य विपणन को लोग, विक्रय की गुणवत्ता को बढा सकते है विस्तृत रूप से तथा धनत्व भी लम्बे समय में। मुझ पर विश्वास करे यह संभव है कि बीमा बेचा जाए तथा अपने सिद्धान्तों को सुसंगता को छोडे बिना।

गैर सुसंगता विक्रय विप्पण समुदाय की छवि को आय तौर से बिगाड़ता है तथा बीमा एजेन्ट की गलत छवि बनाता है जनता की आँखों में बीमा बेचना कठिन कार्य हो जाता है। बीमा क्षेत्र में तथा व्यक्ति एक एजेन्ट के रूप में कई बार बूश बताव प्राप्त करता है बाजार में जो की वह उसके साथ होना नहीं चाहते, आप इसका कारण जानते हैं क्यों। यह इसका भी उदाहरण है बहुत सी बेहतर एजेन्सिया पैदा होने से पहले ही समाप्त हो जाती है। कुछ का गैर पेशेवर आचरण पूरे बाजार को खराब कर देता है। पेशेवर विक्रय का स्वरूप सुसंगत है जो बीमा विक्रय लोगों की छवि को सुधारने में मदद करता है।

> यह इसका भी उदाहरण है बहुत सी बेहतर एजेन्सिया पैदा होने से पहले ही समाप्त हो जाती है। कुछ का गैर पेशेवर आचरण पूरे बाजार को खराब कर देता है।

सुसंगता बीमा विक्रय जरूरत के आधार पर विक्रय भी है। लेकिन किसकी आवश्यकता विक्रय प्रबन्धक या शाखा प्रबन्धक अथवा ग्राहक कोई भी इसके लिए एक अर्थ रखता है वह है ग्राहक की आवश्यकता एजेन्ट की आवश्यकता (कुछ मामलों में लालच) कमीशन अथवा एम डी आर टी के लिए आहिता प्राप्त करने के लिए विक्रय प्रबन्धक का एक सपना होता है कि वह विदेशी नौकरी के लिए आहिता प्राप्त करले शाखा प्रबन्धक जल्द पदोन्नति चाहता है तथा उच्च सहुलियत यही जरूरत होती है। लेकिन इस सब का योजना के चुनाव के सम्बन्ध में अवधि तथा बीमा राशि से कोई सम्बन्ध नहीं है टर्म तथा पैशंन पालसी बेचने के लिए यह कठिन है, कोशिश की यूलिप पालसियों को बीमा समझाये आगे बढ़ाया जाए ऐसा कौन सा जोखिम है जो ग्राहक को जोखिम में प्रति खुला छोड रहा है यह सभी उदाहरण है विक्रय करने के जिनमें ग्राहक के हितों को ध्यान में नहीं रखा जाता।

फिर सुसंगत विक्रय क्या है? यह ठीक पालसी ठीक बीमा राशि के लिए ठीक अवधि तथा माध्य जिसका आधार ग्राहक की आवश्यकता हो। अधिक विक्रय कुल मिला कर एक एकल बुरा अनुदेश सभी पक्षों के लिए है। जिसके कारण पालसी कालित हो जाती है। कम विक्रय बीमाधारक की मृत्यु के समय बहुत ही बुरा होगी क्यों की जो बीमाकर्ता द्वारा दिया जायेगा वह उसके परिवार को आवश्यकताओं को पूरा करने के लिए पूरा नहीं होगा। बहुत बार कम

यदि भारतीय बीमा उद्योग को विकास करना है वह भी सही दिशा में तो बाजार तंत्र की सुस्पष्ट करना होगा जिससे ठीक उत्पाद प्रत्येक ग्राहक की आवश्यकता के अनुसार उपलब्ध हो सके।

विक्रय सामने आता है क्योंकी एजेन्ट इस बात से डरता है कि यदि बडी पालसी को सुझाया गया तो संभव है की छोटी पालसी भी न मिले पाये में भी सुसंगत विक्रय संभव नहीं हो पाता।

आज कल बीमा बाजार में गलत विक्रय के बारे में चिन्ता प्रकट की जाती है। यह चिन्ता समस्या को जानने की जागरूकता है जब तक यह जागरूकता ठीक करने के कदमों से सम्बन्ध कंपनियो द्वारा नहीं की जायेगी बहुत कम उम्मीद है कि बहुत कुछ अधिक हो पायेगा।

यहॉ यह देखा गया है कि 'अच्छा विक्रय' वह आवश्यक ही सुसंगत विक्रय में सभी हितधारियों - ग्राहक, एजेन्ट तथा कंपनियों के लिए संतुष्टि प्रदान करने वाला होगा। ऐसे विक्रय को परिभाषित किया जा रकता है विक्रय स्थिति तथा यह एजेन्ट की छवि को बढाता है साथ ही कंपनी की भी और अन्य के लिए एक आदर्श चलने के लिए बन जाता है।

जीवन बीमा के लिए एक कहावत है कि जीवन बीमा सदा बेचा जाता है बहुत कम खरीदा जाता है। ऐसा बाजार पर्याप्त क्षेत्र रखता है जहा गैर सुसंगत विक्रय होता है तथा गलत विक्रय होता है। केवल उत्पाद जो उच्च कमीशन सखते है वह ग्राहक के हितों के बिना बेचे जा सकते है। यदि स्थितियों को बदलाना है हम अच्छी जानकारी रखने वाली बिमित जनता को बनाना होगा जो उत्पाद को खरीदने समय प्रश्न पूछे कितनी जल्द ऐसा होना संभव है?

कोई संदेह नहीं कुछ किया जाना चाहिये बीमा की जागरूकता फैलाने के लिए बीमा काउंसिल तथा विनियामक के द्वारा। बड़े पैमाने पर प्रिंट तथा इलेक्ट्रानिक मिडिया का प्रयोग जनमत बनाने के लिए तथा जनता के सदस्यों में शिक्षा फैलाने के लिए किया जा सकता है। अन्य को संदेश भेजने के लिए इनसे सम्पर्क हो सकता है। सेबी के पास अभी निधि है निवेशको को शिक्षित करने के लिए। क्यों नहीं हमारे पास एक निधि हो जो साधारण जनता को शिक्षित करना सुनिश्चित कर सके। आज हम अपने बच्चों को 'जीवन कौशल' (जिन्हें सोफ्ट कौशल भी कहा जाता है) को विकसित करने की आवश्यकता क्यों पहचानते है। जिससे वह जीवन में सफल हो सके। यह कौशल कम्प्यूटर कौशल के साथ विद्यालयों में पदाये जाते है। बराबर की यह आवश्कता है कि विद्यातय स्तर पर ही वित्तिय उत्पादों को प्रारंभ किया जाए। जब तक वह अपने कालेज की शिक्षा पूरी करें वह वित्तिय रूप से सक्षय व्यक के रूप में धन बनाने का कार्यकर सकें। हमें बताया गया कि शेयर बाजार के अग्रणिय वारन बुफलेट तथा दुनिया को सबसे धनवान व्यक्ति अपना पहला शेयर 11 वर्ष की आयु में लाये थे और अब वह शेष प्रकट करते है कि इन्होंने देरी से शुरुवात की। युवा लोगों को पकडना तथा उन्हे अपने धन की प्रबन्धन करने के लिए मदद करना उतना ही महत्वपूर्ण है जितना ''जीवन कौशल'' इससे बडा कोई शोध तंत्र गलत बिक्री तथा गैर सुसंगत बिक्री की रोकने के लिए वित्तिय जागरूक ग्राहकों के लिए नहीं हो सकता।

यदि भारतीय बीमा उद्योग को विकास करना है वह भी सही दिशा में तो बाजार तंत्र की सुस्पष्ट करना होगा जिससे ठीक उत्पाद प्रत्येक ग्राहक की आवश्यकता के अनुसार उपलब्ध हो सके। उत्पाद पैकेज अथवा उत्पाद को ग्राहक की आवश्यकता के अनुसार उसके जीवन स्थिति से मिलते हुए होना चाहिए। ये सिद्धांत की एक तरफ की फिटिंग स्वीकार्य नहीं है। अमेरिका क मॉइल को भारत में उतारना कोई बात सिद्ध नहीं करेगा क्योंकि दो देशों में स्थितियाँ बहुत अलग-अलग होती है। हमें जरूरत है एक सुसंगत एजेन्सी बल की जिसे बीमा के मूल्य सिद्धांती की अच्छी जानकारी हो तथा प्रयत्न उत्पाद जानकारी हो तथा ग्राहक की क्षमता, जरूरत की जान सके तथा ठीक बीमा उत्पाद की सिफारिश कर सकें जो ग्राहक की जरूरती की पूरा करें। यह ही गलत विक्रय की घटनाओं की कम करेगा तथा बीमा विक्रय प्रतिनिधि की साश्त की बढ़ाएगा।

मेरे जैसे लोग जिन्होंने जीवन बीमा उद्योग में काफी साल गुजारे है से पूछा जाता है की भावी ग्राहक के लिए बेहतरीन पोलेसी तथा बेहतरीन कंपनी जो बीमा उत्पाद बेचती है का सुझाव दे। ज्यादातर कंपनियाँ थोडा या ज्यादा एक से उत्पाद बेचती है बेहतर कंपनी वी होती है जो किसी विशेष स्थान पर सेवा के लिए जानी जाती हो और सबसे अच्छी पालसी बह होती है जो ग्राहक के लिए बेहतरीन रूप से फिट हो सके तथा वहन योग्य ही। ऐसा कहते हुए मैं अब कुछ योजनाओं का वर्णन करूंगा तथा उन जरूरतो का जिन्हे ये पूरा करती है।

नए बीमा कर्ता की साश्व के लिए यह कहना ही होगा की उन्होने टर्म बीमा तथा पेंशन बीमा के विभिन्न प्रकार की प्रसिद्धी दी है यह दोनों योजनाए एक साथ हमें बडे जोखिम से निपटने में मदद देती है हम समय से पूर्व मृत्यू से साक्षात्कार करते हैं तथा जोखिम लंबे समय तक जीने का।

आइये पहले टर्म बीमा लें। इसे सामान्यता ''शुद्ध बीमा'' कहा जाता है यह वह पालसी है जिसे जीवन के प्रारंभिक वर्षा में एकल अथवा विवाहित होते हुए लेना चाहिए आप जब युवा हो तथा अपनी पहली नौकरी में हो एकल ही या विवाहित आपको बीमा की अवश्य आवश्यकता है आगर आप विवाहित है तो प्राकृतिक रूप से आपको बीमा चाहिए। आपके जीवन में एक महिला है और ऐसा करते हुए आप अपने कर्तव्यों से जिनमे उसके लिए आपकी समय से पहले मृत्यू के लिए सुरक्षा देने से बच नहीं सकते। एकल होते हुए भी इसकी बराबर जरूरत है आपके वृद्ध अभीभावक होंगे जिन्होने आपके लिए बहुत सी कुर्बानियाँ दी होगी जो अब आपकी और जीवन की शाम के समय देखती है। कुछ जरूरते जैसे उच्च शिक्षा अपने से छोटी का विवाह भी हो सकता है। आपके खर्चे इन सब उत्तरदायित्वों के लिए ऊँचे हो सकते है, टर्म बीमा इसका उत्तर है ऐसे ऊँचे से ऊँचे आवरण के लिए जाए जिसका भुगतान आप कर सकें। टर्म बीमा

केवल जीवन बीमा पोलेसी है जो वित्तिय पेशावरों के लिए बीमा की वकालत करती है। टर्म तथा निवेष करे ऐसा कहा जाता है। निसंदेह अच्छी सलह, लेकिन सादारण मनुष्य हमारे जैसे के लिए काम नहीं करता हम जरूरी टर्म को क्रय करेंगे लेकिन क्या हम नियमित रूप से बचे हुए धन को पोलेसी अवधी में निवेश कर पाएगी? उत्तर होगा नहीं।

लोग इसलिए भारत में जबसे प्रचलित पालसी एंडोमेंट पालसी लेते है। जो टर्म प्लान तथा बचत प्लान का सम्मिश्रण है इस पालसी को ठीक रूप से कहे तो (भारतीय दीवानापन) कहा जा सकता है तथा यह भारतीय बाजार में नियमित रूप से राइडर अथवा यूलिप के साथ उपलब्ध है। यह पोलेसी सभी स्थितियों तथा सभी मौसमों में उपलब्ध है।

मनो वैज्ञानिक रूप से यह पोलेसी काफी संतुरती प्रदान करती है। भारतीय बीमा ग्राहक पोलेसी की अवधि पूरा होने पर ''धन'' देखना चहता है। ऐडीमेट आपको यह प्रदान करता है टर्म नहीं। मध्यमवर्ग के लोगों के लिए उनका भविष्य निधि तथा बीमा प्रिमियम मात्र बचते है इसलिए एंडिमेट पोलेसी बचत आदतों की प्रोत्साहित करती है।

वह विधित ही है की टर्म पोलेसी में यदी ग्राहक अंत तक जीवित रहे तो उसको असंतुष्टी होती है यह वह असंतुष्टी है जिसने सामुहिक निवेश ''लिंक बीमा'' की जन्म दिया है, सम्मूह बीमा सिक्ति में प्रिमियम की वापसी व्यक्तिगत बीमा के लिए नहीं होती।

> यूलिप में कुछ भी खराबी नहीं है खराबी उस में है जिस प्रकार कुछ कंपनियों ने इनको डिज़ाईन किया है तथा कुसंगत विक्रय के लिए क्षेत्र छोड दिया है

1970 के अंत में मुझे एक रूचिकर बात से सामना करना पड़ा एक भारतीय जो अमेरिका में स्थापित हो तथा वह एम डी आर टी एजेंट बना। वह यह नहीं समझ सका की भारत में बेचे जाने वाली अधिकांश पोलेसियाँ एंडोमेंट क्यों है। वह यह भी जानना चाहता था की क्यों उसके सहभागियों द्वारा संपूर्ण जीवन पोलेसियाँ भारत में नहीं बेची जाती जबकी अमेरिका में संपूर्ण जीवन पोलेसियाँ काफी प्रचलित है। इसके कई कारण हो सकते है।

पहला इच्छा की पोलेसी अवधि समाप्त होने पर कुछ सकम हाथ में रहे, दूसरा भारत में अधिकांश लोगों की आय एक समय के बाद समाप्त हो जाती है इसलिए वह टर्म पोलेसी अंत में धन प्राप्त करना चाहते है जैसे कि सेवानिवृति के बाद कर्मचारी अपने सेवा निवृत्त लाभों को देखते है यह भी संबंध रखता है कि ऐसा भी कुछ समय था जब बीमा कर्ता के पास बहुत कम वार्षिक तथा टर्म पोलेसी अपनी पुस्तकी में भी।

इसने हमें प्राकृतिक रूप से वार्षिक पर चर्चा के लिए अग्रिसित किया अच्छी खबर यह है की ये उत्पाद अब अपेक्षाकृत बड़ी मात्रा में बेची जाती है यूनिट लिंक योजनाओं के साथ। यहाँ अच्छे विकास के बारे में चर्चा करती होगी: वार्षिक खरीदने वाले अधिकांश लोग यूवा है जैसा की पहले नहीं था। हम में से बहुत से लोगों ने वार्षिक को जपनी सेवा निकृत्त निधि से खरीदा। लंबे समय तक जीने का डर अब हम सबको साताना बंद कर दिया है। अपनी वार्षिक पोलेसी की जब खरीदिए जब आप युवा हो तथा जब चक्रवृद्धि के जादू का नाम है इस प्रकार आपकी नियमित आय प्राप्त होमी जब आप सेवा निकृत्त होंगी जो की आपकी अंतिम लिए गए वेतन से भी अधिक होगा। आपकी जीवनशैली में सेवा निवृत्ती के बाद कोई गिरावट नहीं आएगी तथा आप जीवन के अंत तक सीर उठाकर बिना किसी पर निरभर हूए जी सकेंगे टर्म खरीदिए वार्षिकी खरीदिए जब आप युवा हो आपको जीवन के अंत तक शांती मिलेगी।

यह चर्चा विवादास्पद युलिप पर चर्चा के बिना समाप्त नहीं होगी यूलिप में कुछ भी खराबी नहीं है खराबी उस में है जिस प्रकार कुछ कंपनियों ने इनको डिज़ाईन किया है तथा कुसंगत विक्रय के लिए क्षेत्र छोड दिया है इसने विनियामक को मजबूर किया है कि कठिरात से इसे साफ करने के लिए मार्गनिर्देश जारी करें। यह मार्गदर्शन इस बात को स्पष्ट करते हैं कि बाजार में जिस प्रकार यह उत्पाद बेचे जा रहे तो उसमे कुछ गलती थी। विनियामक द्वारा जो कमियाँ निकाली गई उसमे

- बीमा आवरण उचित नहीं था
- उत्पाद की शर्ता में कोई पारदर्शता नहीं थी
- बीमा उत्पादी के लबे समय के चरित्र की ठेगा दिखा दिया गया
- कंपनी तथा विक्रय करने वालों ने प्रकटिकरण के अभाव मे ग्राहक के लिए निर्णय लेना असंभव बना दिया। इन कठिनाओं की देखते हुए पाया गया की बीमा उत्पाद एक निवेश उत्पाद के रुप में बेचे जाने लगे। शर्तो में इतना स्थान था की विक्रय करने वालि बडे कमिशन के चलते गलत विक्रय करें तथा अनुचित लाभ उठाएं। उत्पाद बीमा कर्ता के लिए अच्छे थे जिन्होने नियम में अप्रत्यशित वृद्धि दर्ज की लेकिन क्या यह ग्राहकों के लि अच्छे ते जो बाजार जोखिमों के साथ संवेदि सूधकांक के मिरने के प्रभावित हो सकते थे।

नई कंपनीयों के उभरने से सुसंगत विक्रय में क्या बडा बंदलाव आया है यह कई प्रश्न चिह्न है। प्रतिस्पर्धा के कारण छोटे समय में गहन परिणाम प्राप्त करना एक चिंता का विषय है। जिसमे उसके प्रमाण मिलते है कि सुसंगत विक्रय का कोई प्रयत्न नहीं किया गया।

वर्तमान परिस्थितियों में हम बीमा के ग्राहक से केवल यही कह सकते है की ''ग्राहक सतर्क रहे'' उसे सतर्क निर्णय लेने केलिए ज्ञान प्राप्त करना चाहिए यदि ऐसा नहीं होता तो उसे न्यायामित्र अथवा किसी कंपनी के कार्यकर्ता से संतुष्टी प्रथा प्राप्त करती चहिए की उसे जो बताया गया है वैसे ही है अन्यया उसे दुख होगा। मै यहाँ यह बताना चहता हूँ की बीमा उद्योग में मेरी लम्बी सेवा में अनेक अवसर आए हैं। जब मैं ने स्पष्टीकरण, सलाह तथा संतुष्टी दी उन लोगों की जिन्होंने शक के कारण मुझसे संपर्क किया।

लेखक भारतीय जीवन बीमा निगम से सेवा निवृत कार्यकारी निदेशक हैं।

21वीं शताब्दी में जोखिम प्रबन्धन - बीमा उद्योग की भूमिका

जी वी राव कहते हैं कि बीमा के लिए कच्चा माल जोखिम है, और आगे कहते हैं जोखिम का संसार नाटकीय ढंग से बदल रहा है बीमाकर्ताओं को यदि सफल होना है तो उन्हें तैयार रहना होगा।

जोखिम प्रबन्धन परिदृश्य में प्राशुलक मूकि का प्रभाव

जनवरी 2007 से प्राशुल्क की सत्ता की समाप्ति के बाद जोखिम का मूल्यांकन प्रबन्धन लेखाजोखा दर निर्धारण एकल गैर-जीवन बीमा कंपनियों पर धीरे से आ गया है। प्रतिस्पर्धा बाजार तथा दर मोल भाव के नियम, दो समझौते वाले दलो में जोखिम स्थानांतरण के लिए नाटकीय परिवर्तन हुए है जिन्होंने भारतीय बीमा बाजार का चारित्र ही बदल दिया है। बीमाकर्ताओं के लिए अब अनिवार्यता है कि वे जोखिम से स्बन्धित सूचनाएँ बीमाकर्ता से माँगे प्राप्त करे तथा जाने जिससे उनसे लेना देना हो सके जो कि परस्पर संतुष्टि प्रदान करेगा। ले या छोड दे स्थिति अब बदल गई है अब चर्चा करने का समय आ गया है।

ग्राहक के लिए प्रिमियम की दर ही चिंता गै विषय है एक बीमाकर्ता के लिए किसी जोखिम को स्वीकार करना प्रबन्धन करना उसके प्रिमियम पर को संविदा भाव देना एक अतिरिक्त मामला बन गया है। बीमाकर्ता किस प्रकार इसके लिए तैयार है। वर्तमान मुक्त बाजार में ऐसे पेशेवर दुर्वह कार्य करना तथा किस शिक्षित वक्र पर यह भविष्य को निर्धारित करेगा।

जनरल एसोसिएशन की साधारण सभा को सम्बन्धित करते हुए दिनांक 26 मई 2000 को जूरिख में एस सी ओ आर के मुख्य कार्यपालक श्री डेनिस कैसलर ने जोखिम के सर्वव्यापि होने के बारे में कहा कि यह निरंतर और तीव्र गति से बढ़ रहा है तथा बदल रहा है। इस प्रक्रिया को स्वागत किया जाना चाहिए क्यों कि बीमा व्यवसाय के लिए कच्चा माल कई प्रकार के जोखिमों से जुडा है - यह सतत् रूप से बढता रहेगा। जोखिम के वर्तमान स्वरूप में अन्देखे, बढ़े परिवर्तन आ रहे है तथा हाँनिया भी जल्द जल्द तथा पृथक-पृथक रूप से हो रही है। नयी जोखिम प्रबन्धन तकनीके सामने आ रही है बढती हुई जोखिम की जटिलता के लिए जिससे उन्हे निमन्त्रण में बेशक न रखा जा सके पर जॉच में रखा जा सके।

> ग्राहक के लिए प्रिमियम की दर ही चिंता गै विषय है एक बीमाकर्ता के लिए किसी जोखिम को स्वीकार करना प्रबन्धन करना उसके प्रिमियम पर को संविदा भाव देना एक अतिरिक्त मामला बन गया है।

बीमा के लिए कच्चे माल का स्रोत क्या है?

भारतीय बीमाकर्ता या तो अनदेखा कर देते है या भूल जाते हैं - पिछले पाँच दशकों से प्राशूल्क सत्ता के होने के कारण - कि वे बीमा व्यवसाय में है और लगातार बाजार में नये जोखिम को माँप नहीं पा रहें। जोखिम प्रक्रिया को स्वयं के व्यवसायिक हितो के आगे आत्म केन्द्रित होते हुए आगे नहीं भाँप पा रहे हैं। जोखिम केवल कच्चा माल है जो आत्म केन्द्रिय बीमा उद्योग के लिए जरूरी है इसके बिना उद्योग का होने का कोई तर्क नहीं है। वर्तमान में कैसे भारतीय बीमकर्ता कच्चा माल के रूप में जोखिम से रख रखाव कर रहे हैं जो उन्हें दिया गया है।

इस लेख की स्थापना

जोखिम प्रबन्धन, बीमाकर्ता को अनुमान लगाना होगा एक ऐसी मूल प्रक्रिया का जिससे जोखिम को प्रक्रिया में ढाला जा सके उन बीमा लेखनकर्ताओं के लिए जिससे अंतत प्रिमियम मूल्य निर्धारित किया जा सके। यदि किसी ग्राहक को उसे स्वीकार करना हो वह बीमा उत्पाद के अंतिम रूप जिसे पालसी दस्तावेज कहते हैं में परिवर्तित हो सके। प्रत्येक, बीमाकर्ता की प्रतिस्पर्धात्मक उत्कृष्टता इससे सामने आयेगी की कैसी उच्च जोखिम प्रबन्धन प्रक्रिया प्रत्येक के लिए है जिसे मूल्य को सुर में गया जा सके।

> हानि की संभावनाओं को कम करना तथा उनकी हानि की क्षमताओं की कम करना बीमा का मूल प्रयोजन समझाना चाहिए तथा विशेषता की मिनती होती है।

बीमाकर्ता जिस जोखिम प्रबन्धन प्रक्रिया को उदारता के साथ देखता है वह दो धारणों में प्रभावित होती है, पहली जोखिम प्रबन्धन प्रक्रिया जोकि पहले से ही उपलब्ध है तथा उस पर बीमाकर्ता तथा उसके स्टाफ द्वारा व्यवहार किया जाता है तथा अन्य, जोकि बीमाकर्ता इच्चा सखता है, जोखिम प्रबन्धन के उस भाग के रूप में जिससे हानि निमन्त्रण के उपाय को अनुपालित किया जा सके यह प्रक्रिया बीमाकृत को कई प्रकार की दरों को जानने विकल्प प्रदान करेगी। प्रिमियम पर निसंदेह बाध्यकारी बाजार बल का परिणाम है, लेकिन जोखिम प्रबन्धन के आधारभूत की वांधना दोनो दलो को है जिनका संयुक्त लक्ष्य है - कि हानि की संभावनाओं को कम किया जाए, तथा उनकी हानि क्षमता क्यो कम से कम किया जाए। बीमा के स्थाई प्रयोजन को समझना चाहिए। विशेज्ञता की गणना होती है।

एक बीमाकर्ता अंततः जोखिम प्रबन्धन के लिए जो नम्रता चाहता है वह दो भागों में प्रवाहित होती है। पहला जोखिम प्रबंधन प्रक्रिया के रूप में जैसे की पहले से ही उपलब्ध है तथा जिस पर अमल किया जाता है बीमाकर्ता की इच्छा है बीमा कर्ता जोखिम प्रबंधन कार्यक्रम के भाग के रूप में सुनिश्चित किया जा सके यह प्रक्रिया बीमा कर्ता के लिए सुनिश्चित करेगी की अधिक दशो के विकल्प सुझाएं जा सके प्रिमियम दर निसंदेह एक निश्चित बाजार बल के कारण लेकिन जोखिम प्रबंधन के आधारभूत कारकों के कारण दोनों दलों की इच्छाओं के संयुक्त लक्ष्य - हानि की संभावनाओं को कम करना तथा उनकी हानि की क्षमताओं की कम करना बीमा का मूल प्रयोजन समझाना चाहिए तथा विशेषता की मिनती होती है।

बीमाकर्ता लंबे समय का अपने व्यवसाय का बिंदू बनाते है जिन्हें जोखिम प्रबंधन प्रक्रिया तथा उसके नम्रता से गुजरना होगा एवं वर्तमान के मूल्य पर ही निर्भर नहीं करना होगा। केवल मूल्य के कारकों से ही निरभर ना रहते हुए। बिना किसी संबंधित माँग के जी बीमा कर्ता के जोखिम प्रबंधन प्रक्रिया की ऊपर ले जाने के लिए की जाती है वह केवल बीमा कर्ता को दुखी करेगी निचली देखा तथा यदी बाद में मूल्य की बढ़ाना हो ऐसे में केवल बीमा कर्ता की परेशानियों बढेगी ऐसी आशा की जाती है की बीमा कर्ता इस बात से जागरूक है की यदी इस प्रणाली को आगे बढागे तो वह स्वयं द्वारा खड़ी की गई परेशानी में फँस जाएंगे बीमाकृत की दर की कम करने की सभी माँगे जोखिम प्रबंधक प्रणाली की मजबूत करने से जुडी होनी चाहिए।

हम किसकी चर्चा करेंगे

यह लेख मुख्य रूप से दिखने वाले परिपाटियों जिनका प्रभाव वर्तमान जोखिम पर पडता है तथा नए जोखिम को स्थान देती है। इस प्रभाव के कारण भाह्यवातावरण का दबाव बदलता है तथा बीमा कर्ता का प्रबंधन भी है। यह आशा की जाती है की बीमा कर्ता एक गंभीर परिचर्या में शामिल होंगे - उस परिवर्तन के प्रति जो उनके मूल उत्पादों के विक्रय के लिए है जो साधारण जनता को बेचे जाते है जैसे की बीमा कार्ता का जोखिम प्रबंधन - यह नियंत्रण करेगा तथा बीमा उद्योग के नए उभरते हुए जोखिम सवेरे को नियंत्रित करेगा।

जोखिम प्रबंधन क्षेत्र में बीमा उद्योग की कार्यशीलता को परखा जा सकता है उस माप दंड से जिसके द्वारा वे जोखिम को स्वीकार करते है तथा कैसे किस उच्च प्रबंध जोखिम को अपनी दखलअंदाजी ने मदद कर सकते है हानि शोधन तथा हानी नियंत्रण नहीं प्राशुल्क सत्ता की समाप्त करनी एक बडा अवसर है लेकिन बीमाकर्ता किस प्रकार तैयार है भविष्य के जोखिम प्रबंधन के परिपेक्ष को बदलने के लिए उनके लिए शब्द दिया जाएगा सच्चे बीमा पेशेवर ना की अच्छे बीमा प्रशासक?

भूत काल का लेन देन पैटर्न

उनके अंशदान पर चर्चा करने से पहले हमें उसकी कभी के यह जानना होगा की वे क्या है जो बीमा कर्ता को इस संतुष्ट स्थिति में लाया है। जोखिम स्वीकार करने की प्रक्रिया अब तक प्राशुल्क में दिए गए प्रिमियम ढाँचे पर निर्भर थी। यह सत्ता विधान द्वारा को तारकिक मस्तिष्क का प्रयोग जोखिम के लिए करने की आवश्यकता नहीं थी और यह जरूरी भी नहीं था वैसे किसी आवेदन को सीखना तथा जानना बीमा कर्ता को मूल्य निर्धारण भी प्रारंभ में मदद नहीं देखा। जानने की प्रक्रिया केवल अतिरिक्त लोगों में प्रतिफलित होगा क्या कोई मुद्दात्मक प्रतिफल प्राप्त नहीं होगा।

ग्राहक को ऐसा संदेह देना की उनकी बीमा करने की आवश्यकता है नाकी उनको जोखिम प्रबंधक परिपाटी में उत्कर्षता लाना मान एक लक्ष्य है बीमा कर्ता की प्रभावित करने के लिए है। एक प्रकार से वह अपनी भूमिका बीमा आवरण प्रदान करने के रूप में देकते हैं ना की बीमाकृत की बीमा प्रबंधक के रूप में उद्योग को हमेशा से प्राशुल्क सलाहकार समिति (टीएसी) एक वैधानिक संस्था द्वारा दर निर्धारण को सर्वव्यापक बनाने के लिए किया जाता था। प्रतिस्पर्धा एक काल्पनिक तत्व के आधार पर सेवा की थी लेकिन दर में कोई विचित्रता नहीं थी। बीमा को दूर-दूर तक पहूँचाना अरकार का मुख्य लक्ष्य था।

अब, प्राशुल्क मुक्ति द्वारा व्यवसाय जीवन के एक कारक के रूप में एकल बीमा कर्ता यकायक जोखिम के नए संसार में पहूँच गए हैं जिसके बारे में इन्हे कोई व्यक्तिगत अनुभव नहीं है दर को ध्यान में रखते हुए। भिन्नतपूर्वक तथा प्रतिस्पर्धा दर निर्धारण की अनुमति है जबकी जोखिम की विविधा अलग हो या ना ही जोखिम के भार की विशेषता द्वारा वर्गीकृत करना तथा दर निर्धारण स्वतन्त्र रूप से करने के लिए अलग-अलग

स्तर के ज्ञान की आवश्यकता उस संपत्ति के लिए है तथा तर्किक क्षमता सांकिकि को अर्थ में बदलने के लिए मामले अधिक उलझते हुए जोखिम का संसार नाटकीय रूप से बदलने हुए जोखिम परिदृष्य की अवधारनि की जुड़े भूतकाल में है। यह बीमा कर्ता के लिए मानसिक रुकावट बना है जबकी संसार की आधुनिक जोखिम प्रबंध प्रक्रिया तीव्रता से बदल रही है।

बीमा योग्य जोखिम का तथा संसार

जोखिम का संसार बिना संस्थान के आगे बढा है भूमंडलीय करण के बाल के परिणाम स्वरूप जोखिम परिदृष्य बदला है नई तकनीकें, आयु मे परिवर्तन लिंग, संस्कृति उम्मिदें तथा आय, वातावरण में परिवर्तन आर्थिक प्रगति इत्यादि ने समाज में जोखिम की नई बड़ी बात प्रस्तुत की है त्वरित धन्यवाद सेवा के स्तरो की जानने का मापदंड बना है जलवायु परिवर्तन प्राकृतिक जोखिमों की प्रभाव की बता रहे हैं नई वैद्यानिक निर्देश नए दायित्वों की बाध्य करती इस विश्व में इंटरनेट की बढ़ी हूई जटिलता ने तथा आयाम प्रस्तुत किया है ''जोखिम का बडजाना'' आधुनिक आर्थिक गतिविधियों के संबंध मे एक महत्वपूर्ण स्वभाव रखता है बताईए बढती हुई प्रवृति है। बाड विधुत की कभी ला सकती है जिसके कारण प्रितिशण गृह बंद हो सकते है जो उनमें रखी सामाग्री को नष्ट करेंगे जिसके कारण बाजार अंश की हानियाँ होती है। हानी की कई परिणाम स्वरूप एकल दुर्घटना से अनेक असंबध हानियों के प्रभावित कर सकती है। यह अब काफी नहीं है की केवल एक जोखिम को जाए, व्यक्ति की समुदाय के जोखिम को पायि पहले देखना होगा तथा उनसे जुडी परस्पर प्रभाव को भी जोखिम का परस्पर जुडना दूसरी चुनौती है। जोखिम अंतर संबंध तथा अंतर आधारित बढ़ते हुए रूप से ही रहे है बहुत रूप से लेकिन सूक्ष्म रूप से हानी की संभावना महा विपदा की ही भई है।

> औसत लागत तथा संभावना को जोखिम के द्वारा कम करने का दबाव बढ़ रहा है यह भी दबाव है कि जोखिम के विस्तार को रोका जाए।

अदृश्य संपत्तियों का बीमा

बीमाकर्ता अब असफल रूप से दृश्य सामान के जोखिम की सुरक्षा प्रदान करते है जबकी उनकी पहचान तथा निरीक्षण किया जा सके। लेकिन बढ़ते हुए सेवा उद्योग में अदृश्य संपत्तियों से लेन-देन करने की नई चुनौती सामने रखी है बीमाकर्ता से कहा जाता है वह ''उत्कृष्ट सलाह'' जो वित्तिय दायित्व तथा छवि की इज्जत के मामले की सामने लाए।

मैनुफैक्चरीग तथा सेवा उद्योग के भूमंडलिकरण ने प्रणाली में उत्तीर्ण न होने देने अन्तराष्ट्रीय अपराध काले धन को वैध बनाने बीमा के डेरोवोटिव्स तथा क्रेडिट स्वैप की महामारी को फैलाया है।

स्पर्श योग्य संपत्ति तथा स्पर्श न किये जा सकने वाली संपत्तियों के बीमे की माँग में तीव्रता से बढ़ौतरी हुई है, भारत में कम से कम जहा बीमा की व्यापकता का स्तर कम है। लेकिन अर्थव्यवस्था के भूमंडलिकरण के कारण यह तथ्य सामने आया है कि भारतीय बाजार भी उन माँगो को पुरा करे जो स्पर्श योग्य तथा स्पर्श न की जाने वाली संपत्तियों के रूप में सेवा उद्योग ने सामने लाया है। भारतीय बीमा कर्ता कितने तया है कि वे इसे अवश्यक ज्ञान व निपुणता से निपट सके। इतने बडे जोखिम परिदृष्य में? परंपरागत रूप से जोखिम भी बदलाव की स्थिति में है, ग्राहक के जोखिम पक्ष के कारण इससे बदलाव आया है। इससे भारतीय बीमाकर्ताओं का क्या सीखना चाहिये उसकी विशेषज्ञता यह जानकारी प्रक्रिया के मूल में है।

जोखिम दृष्टिकोण की प्रकृति को बदलना

जीवन बीमा पहले माँगा जाता था एक परिवार की आवश्यकताओं के लिए, बीमाकृत की असमय हुई मृत्यु के लिए। अब जल्द मरने का डर कम हो गया है। लेकिन वृद्ध अवस्था में बिना वित्तिय साधनों के जीवित रहने का डर में बदल गया है। इसलिए सभी को जीवन बीमा को नये प्रकार में देखना होगा। जीवन बीमा में जोखिम दृष्टिकोण बदला है। यूलिप ने लोगों को जीवन बीमा की तरफ मोड़ा है यह न केवल एक साधन है जीवन बीमा आवरण क्या लेकिन बचत तथा निवेश का भी।

यह भी कठिन हो गया है कि बीमाकर्ता के ऐच्छिक जोखिम वाले पक्ष तथा उसका ऐसे न चाहने वाले पक्ष में भेद कैसे किया जाए। व्याक्तिगत दुर्घटना बीमा कुछ दूसरा है। जबकि दुर्घटना की दर लगातार बढती जा रही है। यह बताता है कि आज के जोखिम कम अस्मायिक है तथा दुर्घटना है तथा क्रमिक उत्तरोत्तर की संभावना अधिक है। वातावरण को हानि पहूँचाने के सम्बन्ध में इसका प्रभाव लम्बा और कई बार अपरिवर्तनीय है। जोखिम परिदृष्य में एक परिवर्तन है कि जोखिम अब बाद्यकारी है। अंधेड तथा मौसम सम्बन्धित घटनाए अब पहले से बतायी जा सकती है लेकिन वह कम आकस्मिक है। बीमाकर्ता अब जोखिम सम्बन्धित जानकारी प्राप्त करने के सम्बन्ध में अधिक विकसित स्थिति में है। जिससे महामारी तथा बीमारी शामिल है जो कुछ समय पहले तक जानना संभव नहीं था।

(शेष भाग अगले अंक में)

लेखक भूतपूर्व सीएमडी, ओरियन्टल इंशूरेंस क.लि.

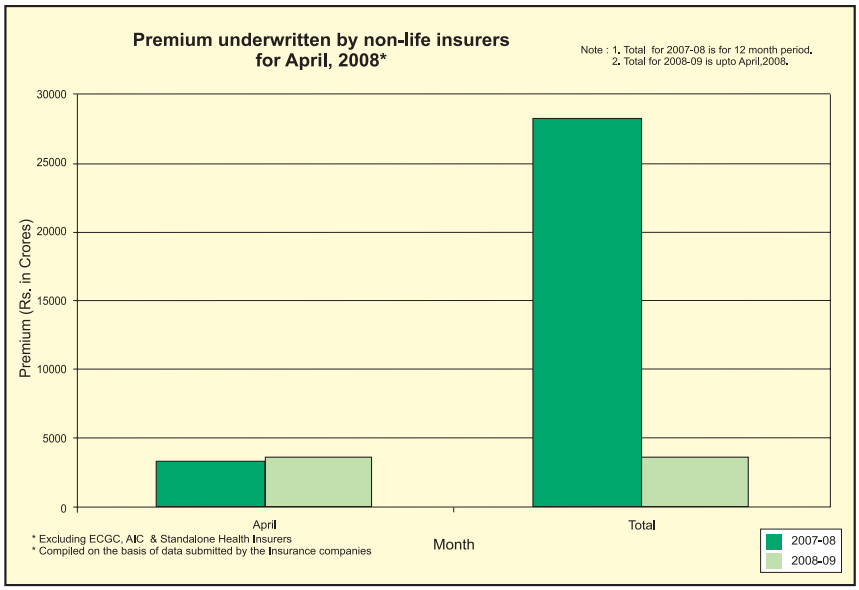
Report Card: General

GROSS PREMIUM UNDERWRITTEN FOR AND UP TO THE MONTH OF APRIL 2008

(Rs.in Crores)

INSURER	APRIL		GROWTH OVER THE CORRESPONDING PERIOD OF PREVIOUS YEAR
	2008-09	2007-08	
Royal Sundaram	74.15	72.92	1.69
Tata-AIG	147.97	112.06	32.05
Reliance General	273.94	221.16	23.87
IFFCO-Tokio	142.22	107.24	32.62
ICICI-lombard	543.28	448.65	21.09
Bajaj Allianz	276.14	215.34	28.23
HDFC ERGO General	14.61	21.89	-33.25
Cholamandalam	95.04	72.96	30.27
Future Generali*	10.37	0.00	
Universal Sompo**	0.13	0.00	
New India	693.61	654.18	6.03
National	456.47	395.89	15.30
United India	437.32	407.35	7.36
Oriental	427.98	414.17	3.33
PRIVATE TOTAL	1577.85	1272.22	24.02
PUBLIC TOTAL	2015.38	1871.59	7.68
GRAND TOTAL	3593.24	3143.81	14.30
SPECIALISED INSTITUTIONS			
Credit Insurance			
ECGC	47.06	37.77	24.58
Health Insurance			
Star Health & Allied Insurance	58.21	33.99	71.24
Apollo DKV*	1.50	0.00	
Health Total	59.71	33.99	75.66
Agriculture Insurance			
AIC	21.07	23.67	-11.00

Note: Compiled on the basis of data submitted by the Insurance companies
** Commenced operations in November, 2007.*
*** Commenced operations in February, 2008.*



GROSS PREMIUM UNDERWRITTEN BY NON-LIFE INSURERS WITHIN INDIA (SEGMENT WISE):

Sl. No.	Insurer	Fire	Marine	Marine Cargo	Marine Hull	Engineering	Motor
1	**Royal Sundaram**	**69.65**	**18.27**	**17.87**	**0.40**	**41.10**	**410.18**
	Previous year	*99.08*	*18.44*	*17.85*	*0.59*	*40.13*	*303.39*
2	**TATA-AIG**	**133.25**	**97.92**	**97.92**	**0.00**	**29.29**	**265.01**
	Previous year	*130.25*	*71.31*	*71.31*	*0.00*	*26.29*	*288.09*
3	**Reliance**	**127.81**	**42.41**	**31.64**	**10.77**	**103.54**	**1,267.37**
	Previous year	*146.16*	*24.92*	*16.45*	*8.47*	*93.68*	*455.06*
4	**IFFCO Tokio**	**234.80**	**69.45**	**56.88**	**12.57**	**89.12**	**582.24**
	Previous year	*294.76*	*129.96*	*52.24*	*77.73*	*90.91*	*448.90*
5	**ICICI Lombard**	**438.25**	**224.55**	**67.27**	**157.28**	**179.51**	**1,279.77**
	Previous year	*403.05*	*155.25*	*56.23*	*99.02*	*177.54*	*1,143.34*
6	**Bajaj Allianz**	**287.53**	**76.41**	**67.49**	**8.92**	**145.92**	**1,385.82**
	Previous year	*381.19*	*72.99*	*60.43*	*12.56*	*154.60*	*843.87*
7	**HDFC ERGO**	**7.09**	**3.14**	**3.14**	**0.00**	**6.69**	**134.80**
	Previous year	*7.65*	*2.37*	*2.37*	*0.00*	*5.98*	*132.36*
8	**Cholamandalam**	**70.10**	**32.66**	**31.18**	**1.48**	**29.91**	**263.56**
	Previous year	*80.54*	*26.56*	*25.66*	*0.90*	*23.72*	*97.16*
9	**Future Generali $**	**3.37**	**0.72**	**0.72**	**0.00**	**0.99**	**1.77**
	Previous year	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*
10	**Universal Sompo ***	**0.48**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	Previous year	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*
11	**New India**	**743.42**	**437.28**	**182.70**	**254.58**	**222.64**	**2,034.36**
	Previous year	*909.98*	*321.02*	*158.71*	*162.31*	*210.38*	*2,034.73*
12	**National**	**377.52**	**188.52**	**139.20**	**49.32**	**145.71**	**2,143.69**
	Previous year	*491.21*	*196.97*	*120.29*	*76.68*	*134.95*	*1,980.16*
13	**United India**	**524.30**	**300.83**	**192.10**	**108.74**	**216.68**	**1,434.90**
	Previous year	*674.77*	*264.35*	*135.31*	*129.05*	*203.96*	*1,219.18*
14	**Oriental**	**499.72**	**343.54**	**163.50**	**180.04**	**221.23**	**1,600.25**
	Previous year	*538.50*	*349.78*	*168.76*	*181.02*	*214.27*	*1,732.26*
	Grand Total	**3,516.80**	**1,835.72**	**1,051.62**	**784.10**	**1,432.34**	**12,803.71**
	Previous year	*4,157.14*	*1,633.93*	*885.61*	*748.32*	*1,376.40*	*10,678.50*
	SPECIALISED INSTITUTIONS						
15	**ECGC**						
	Previous year						
16	**Star Health & Allied Insurance**						
	Previous year						
17	**Apollo DKV $**						
	Previous year						

Note: In case of public sector insurance companies, the segment wise data submitted may vary from the flash Nos filed with the Authority. As such, the industry totals may vary from the flash figures published for the month of March-2008.
$ Commenced operations in November, 2007.
* Commenced operations in February, 2008.
Compiled on the basis of data submitted by the Insurance companies

FOR THE YEAR ENDED MARCH - 2008 (PROVISIONAL & UNAUDITED)

(Rs.Crores)

	Motor OD	Motor TP	Health	Aviation	Liability	Personal Accident	All Others	Grand Total
	330.74 *266.68*	**79.44** *36.71*	**108.61** *96.18*	**0.00** *0.00*	**6.28** *8.62*	**30.77** *26.80*	**10.29** *7.94*	**695.16** *600.58*
	221.52 *262.21*	**43.48** *25.88*	**68.91** *45.35*	**0.00** *0.25*	**102.73** *73.47*	**106.46** *79.40*	**9.83** *27.15*	**813.39** *741.56*
	916.23 *408.67*	**351.14** *46.39*	**275.62** *67.69*	**7.42** *7.23*	**14.10** *10.03*	**52.68** *16.47*	**55.47** *91.07*	**1,946.42** *912.31*
	352.70 *348.63*	**229.55** *100.27*	**114.02** *71.89*	**6.38** *4.74*	**32.19** *12.70*	**20.43** *17.44*	**87.19** *79.03*	**1,235.83** *1,150.32*
	906.48 *956.73*	**373.29** *186.60*	**884.61** *735.85*	**41.32** *32.07*	**78.78** *84.02*	**108.18** *113.74*	**109.72** *158.59*	**3,344.69** *3,003.45*
	1,002.86 *668.39*	**382.96** *175.48*	**243.25** *158.26*	**13.95** *9.44*	**47.91** *29.73*	**46.35** *24.20*	**157.21** *129.07*	**2,404.34** *1,803.34*
	119.34 *123.83*	**15.45** *8.53*	**28.10** *10.18*	**0.00** *0.00*	**5.17** *4.76*	**5.38** *7.69*	**26.21** *19.17*	**216.58** *190.16*
	210.26 *80.53*	**53.30** *16.63*	**109.38** *38.60*	**-0.15** *0.40*	**13.88** *14.70*	**12.55** *7.63*	**31.77** *25.27*	**563.67** *314.59*
	1.54 *0.00*	**0.23** *0.00*	**0.00** *0.00*	**0.00** *0.00*	**0.10** *0.00*	**3.43** *0.00*	**0.25** *0.00*	**10.64** *0.00*
	0.00 *0.00*	**0.00** *0.00*	**0.00** *0.00*	**0.00** *0.00*	**0.00** *0.00*	**0.00** *0.00*	**0.00** *0.00*	**0.48** *0.00*
	1,097.30 *1,233.71*	**937.05** *801.02*	**1,209.42** *765.29*	**78.44** *118.08*	**95.65** *60.65*	**83.08** *79.39*	**373.06** *517.68*	**5,277.35** 5,017.20
	1,352.65 *1,310.14*	**791.03** *670.03*	**684.70** *333.12*	**50.97** *84.49*	**41.17** *36.42*	**63.77** *55.24*	**334.75** *501.84*	**4,030.80** *3,814.42*
	707.50 *767.30*	**727.40** *451.88*	**694.94** *434.64*	**26.13** *45.36*	**74.18** *67.79*	**100.82** *95.31*	**366.76** *504.59*	**3,739.56** *3,509.95*
	966.88 *1,158.88*	**633.37** *573.39*	**547.44** *440.53*	**78.98** *119.54*	**70.81** *61.61*	**88.20** *68.62*	**397.82** *415.43*	**3,847.99** *3,940.53*
	8,186.01 *7,585.70*	**4,617.70** *3,092.80*	**4,969.01** *3,197.57*	**303.44** *421.61*	**582.96** *464.49*	**722.10** *591.95*	**1,960.33** *2,476.83*	**28,126.41** *24,998.41*
							669.39 **618.05**	**669.39** *618.05*
			152.95 **11.16**			**15.63** **11.35**	**4.45** **0.00**	**173.03** *22.51*
			2.98 *0.00*					**2.98** *0.00*

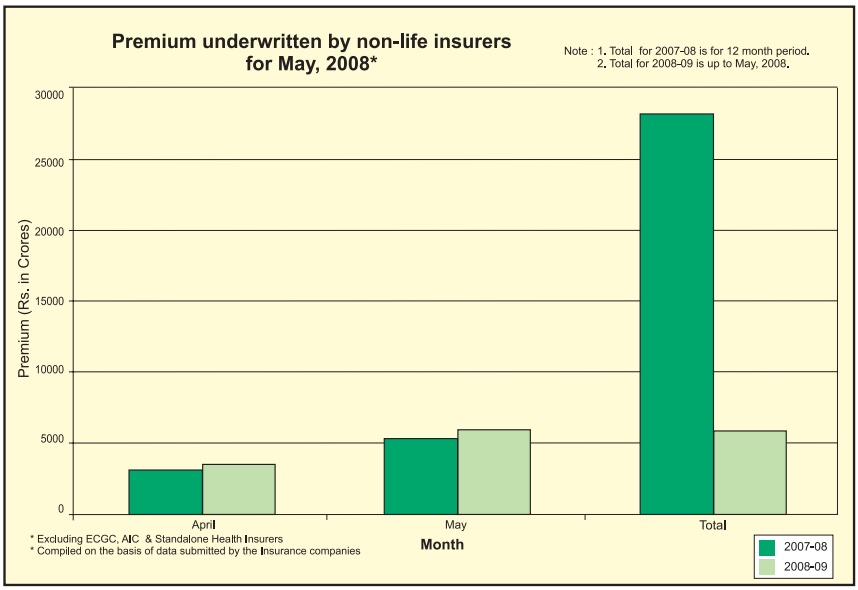
Report Card: General

GROSS PREMIUM UNDERWRITTEN FOR AND UP TO THE MONTH OF MAY 2008

(Rs.in Crores)

INSURER	MAY		APRIL - MAY		GROWTH OVER THE CORRESPONDING PERIOD OF PREVIOUS YEAR
	2008-09	2007-08	2008-09	2007-08	
Royal Sundaram	56.90	49.52	131.05	117.37	11.65
Tata-AIG	74.08	59.98	222.05	172.04	29.07
Reliance General	152.27	141.70	426.22	362.86	17.46
IFFCO-Tokio	132.11	100.81	274.33	208.06	31.85
ICICI-lombard	257.56	202.28	800.84	650.93	23.03
Bajaj Allianz	232.71	175.33	508.85	390.68	30.25
HDFC ERGO General	16.61	12.77	31.22	34.66	-9.93
Cholamandalam	52.42	36.77	147.46	109.73	34.38
Future Generali*	9.19	0.00	19.55	0.00	
Universal Sompo**	0.05	0.00	0.18	0.00	
New India	401.11	378.91	1106.84	1032.61	7.19
National	363.07	328.42	819.54	724.31	13.15
United India	359.44	323.38	796.77	730.74	9.04
Oriental	304.60	329.55	731.63	743.72	-1.63
PRIVATE TOTAL	983.90	779.16	2561.74	2046.33	25.19
PUBLIC TOTAL	1428.22	1360.26	3454.78	3231.38	6.91
GRAND TOTAL	2412.12	2139.42	6016.52	5277.71	14.00
SPECIALISED INSTITUTIONS					
Credit Insurance					
ECGC	57.53	50.31	104.59	88.09	18.74
Health Insurance					
Star Health & Allied Insurance	4.47	1.31	62.68	35.30	77.55
Apollo DKV*	3.94	0.00	5.44	0.00	
Health Total	8.41	1.31	68.12	35.30	92.97
Agriculture Insurance					
AIC	19.67	23.59	40.74	47.26	-13.81

Note: Compiled on the basis of data submitted by the Insurance companies.
** Commenced operations in November, 2007.*
*** Commenced operations in February, 2008.*



A farewell was jointly organized by the Life Insurance Council and The General Insurance Council to Mr. C.S. Rao, ex-Chairman, IRDA on 9th May, 2008 at Mumbai.

On behalf of Life Insurance Council, Mr. S. V. Mony, the then Secretary General, is seen presenting a floral bouquet to Mr. C.S. Rao.

Mr. C.S. Rao warmly reciprocates the gesture of the two councils.

The United States Agency for International Development (USAID) and the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH (German Agency for Technical Cooperation) organized a conference on 'Making Health Insurance Work for the Poor' on May 5-6, 2008 at New Delhi.

Mr. C.S. Rao, the then Chairman, IRDA delivering the Inaugural Address at the conference.

Dr. J. P. Steinmann, Principal Advisor, Health Sector Support, GTZ in India addressing the delegates.

Keynote Address at the conference, being delivered by Mr. G.C. Chaturvedi, Additional Secretary, Ministry of Health, Government of India

07 - 12 Jul 2008
Venue: Pune

Management of Material Damage & Business Interruption Insurance
By *National Insurance Academy, Pune*

8 - 9 Jul 2008
Venue: Tehran, Iran

Insurance in Oil, Gas and Petrochemical Industries
By *Iran Insurance & Petroleum Ministry*

13 Jul 2008
Venue: Taipei

IIS Annual Seminar
By *International Insurance Society, New York*

14 - 16 Jul 2008
Venue: Pune

Prog. on Insurance Management of Energy Risk (Oil & Gas)
By *National Insurance Academy, Pune*

23 - 24 Jul 2008
Venue: Mumbai

Microinsurance: Regulating Insurance for the Masses
By *Asia Insurance Review, Singapore*

28 - 30 Jul 2008
Venue: Pune

Insurance Management Programme for Industrial Customers
By *National Insurance Academy, Pune*

31 Jul - 02 Aug 2008
Venue: Pune

Actuarial Appreciation Programme for Senior Executives
By *National Insurance Academy, Pune*

07 - 08 Aug 2008
Venue: New Delhi

Fostering Quality Healthcare for All
By *FICCI, New Delhi*

11 - 13 Aug 2008
Venue: Pune

Programme on Marketing Strategies (Life)
By *National Insurance Academy, Pune*

21 - 23 Aug 2008
Venue: Pune

Programme on Frontline Marketing Strategies
By *National Insurance Academy, Pune*

RNI No: APBIL/2002/9589

view point

The actuary is responsible for ensuring that the insurer's liabilities are valued, based on sound actuarial principles to enable the insurer to maintain sufficient assets to meet its liabilities when they fall due.

Mr Low Kwok Mun
Executive Director (Insurance Supervision),
Monetary Authority of Singapore

Innovative health insurance programs not only provide timely and affordable healthcare to poor households but also protect them from financially catastrophic health expenses.

Mr George Deikun
Mission Director, USAID India

IRDA has to take proactive steps in spreading awareness among consumers regarding what information they have to seek and what questions should be asked about insurance schemes.

Mr C S Rao
Ex-Chairman, Insurance Regulatory & Development Authority, India

As the world's largest insurance market, the United States serves as a model for developing markets; as well as for the growing efforts to develop international standards of insurance regulation.

Mr Walter Bell
Alabama Insurance Commissioner, and
Chair of the NAIC International Insurance Relations Committee.

The expectations regarding robust management of conflict are higher where the potentially affected parties are seen to be at a disadvantage, because of information asymmetry where one party knows more about the relevant issues at hand than the others.

Mr Ramani Venkatramani
General Manager, Australian Prudential Regulation Authority

The key building blocks to core bank resiliency are strong capital cushions, robust liquidity buffers, strong risk management and supervision, and better market discipline through transparency.

Mr Nout Wellink
Chairman of the Basel Committee on Banking Supervision