



Volume I, No. 2

Journal

JANUARY 2003

Rules for Referees
Arup Chatterjee

Brokers add depth
Vinod Sahgal

Tariffs restrict choice
Peter J Valentine

WAITING FOR

HEALTH

INSURANCE

बीमा विनियामक और विकास प्राधिकरण



Editorial Board:

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A.K. Venkat Subramaniam
Prof. R. Vaidyanathan

Editor:

K. Nitya Kalyani

Hindi Correspondent:

Sanjeev Kumar Jain

Design concept & Production:

Imageads Services Private Limited

Art Director : Shailesh Ijmulwar

Production : Anand and Usha

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Editor: K. Nitya Kalyani

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17, Red Hills, Hyderabad 500 004

and published from

Parisrama Bhavanam, III Floor

5-9-58/B, Basheer Bagh

Hyderabad 500 004

Phone: 5582 0964, 5578 9768

Fax: 91-040-5582 3334

e-mail: irdajournal@irdaonline.org

From the Publisher



More information is always welcome. That is the inference one could draw from the response to the first issue of the **IRDA Journal** in early December. The idea of spreading and exchanging information, and reaching out to the various constituents of the insurance industry through the medium of a publication, was clearly a welcome move going by the way many of you received news of the effort with enthusiasm, and communicated it to us. It was also heartening to receive many personal and written requests at this office for copies from India and abroad.

The Journal is just the first salvo of the Authority for reaching out to the industry and spreading consumer awareness. We plan to use the immense reach of Prasar Bharati, through radio and television, to spread the word about insurance and pensions. Soon on prime time on All India Radio and Doordarshan, there will be serials, short films and programmes projecting the importance of these methods of financial protection.

Along with information, more interaction is also very desirable. And that is a message I cannot repeat often enough.

We are creating a new method of presentation of the Journal from this month. Each issue will start off a debate or discussion on a topic that is of concern to the insurance industry, or a problem that is staring us in the face, and present an overview and a few facets of the subject.

Following that, what we look forward to from you is participation. We are here to listen to you.

The first such matter we want to throw open for discussion is health insurance and that is the focus of the issue you hold in your hands now.

This is a matter that has me concerned on behalf of the Indian people. The middle class and those below it are faced with poor healthcare choices in terms of quality combined with affordability. They have no means of financing what they should have except by spending their savings. Indeed they are hardly aware of the importance of insurance in their daily lives and the security it can lend to their futures, and that is what we in the Authority want to change through our radio and television initiative.

Though health insurance seems an obvious market to tap, nothing big has happened in the last couple of years since what we thought would be a rejuvenation of the industry, with new and old players competing with each other to offer a menu of products and services to the eager customers.

So, the questions are: Though everyone talked of immense market potential, why is health insurance as a product just not taking shape in the Indian market? What really is the market looking for and what roadblocks have to be removed? Finally, how can that be done to give the market what it wants and needs? There are many other questions, small and big and, what I want from you my dear members of the industry, is maximum discussion and participation from all sectors.

Raise the questions and answer them so that we, as a whole, are able to see all sides of the situation and a way emerges that will lead us to the solution. Be free, frank and fair, of course, in your writing, and contribute to the process of consensus building in the industry which has proved to be its strength.

This is the crux of what the **IRDA Journal** wants to work for. If we had been an academic or research body we would be bringing out a publication with research articles and technical papers.

But the IRDA's responsibilities are in the heat and dust of the everyday workings of the industry. It tries to make the way smooth and to chart out paths for the future based on the pulse of the industry and the society today. It also steps back to look at the industry as a whole, and at itself critically, that both may stay strong.

So its publication has styled itself as a bridge between the regulator and the insurance fraternity, to enlarge the role played by myself and my diligent team hitherto, for quick and smooth flow of information and ideas in both directions. What is important is that it should happen both ways.

And this is indeed an appropriate time to talk of two directions, being as we are on the brink of another new year, a time when we can look to the past and to the future. Let us do that together.

Happy New Year!



N. RANGACHARY

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What do you think?

If working on a launch issue is exciting, wait till you get to the second issue! The adrenalin of the pre-launch fever and the sheer exhilaration afterwards are happily mixed with enthusiastic response from readers!

Thank you readers from far and near who have written to us asking for copies and wanting to subscribe! Well, there is no subscription. The **IRDA Journal** is part of the IRDA's ongoing commitment to consumer awareness and industry interaction within itself and with the regulator.

But everything comes at a price and what I would like to ask is your participation! We are here to hear you speak. And to make things smooth and effective we are introducing a new method of presentation of issues.

From now on each issue of the **IRDA Journal** will present a topic of current enthusiasm, excitement, or anxiety for the industry. It will present an overview and some facets of the issue and also some fact and figures. What we then want is your reactions.

Take the opportunity to make yourself heard. React to the main issue itself and to the articles, and propose your own solution or raise questions. Look at it in your unique way and, from what your experience and your intelligence suggest, write what can be done.

IRDA Journal will carry the discussion on in the subsequent issues. And we will be pleased to publish all the reactions we receive, whether they are in the form of short letters, reactions, anecdotes or full-length articles.

In this issue our main focus is Health Insurance. To be precise, why it is not happening in India. After all those promises of healthy health financing to the Indian public, why are insurers coy all of a sudden? Why is it that no health insurance product has hit the market that is even worth thinking for a moment about before signing our Mediclaim renewal forms?

We don't answer these questions – we want you to answer them for us. We have Mr. Alope Gupta, health insurance consultant, who headed Cigna in India till it exited in 2001 the market it never entered, outlining the contours of health insurance systems and concepts. We also present the recommendations of two recent studies on healthcare, health financing and their reforms - one by the CII-McKinsey & Company combine, and the other by a Sub-Group on Health Insurance constituted by the Ministry of Health and Family Welfare – that have touched upon health insurance as well.

We also do a little seeding for issue # 3. We have presented one view on detariffing – which will be the issue focus for the February issue – and want you to start thinking and writing to us about that as well. The Motor Own Damage Detariffing Committee is already actively finding that there are very many views and counterviews on this matter – so let's hear it from you!

And another thing, why don't you write in with your suggestions on what you would like to see in future issues of the Journal. They need not just be ideas that have to be the focus of issues. Developments, plans, even your workshops and conferences are of interest to us!

In other words, YOU are our issue focus, issue after issue. Tell us what you are thinking!

Let us enter 2003 together, with a plan for communication.

Happy New Year!

K. Nitya Kalyani

Brokers Add Depth

Vinod Sahgal

With the announcement of the brokers regulations as also those relating to agents, the market has now been enabled to offer to the insurance buyer the full range of distribution channels.

Thus the clock has been turned back to the pre-nationalisation era providing a multiple choice as to how, from whom and through whom to buy insurance – with the additional facility of having an insurance intermediary who can and will represent him and not only the insurer.

This is not to say that the intermediaries pre-nationalisation (agents, principal and chief agents) did not represent the insurer, but they that did it differently from those who functioned during the 50 years of life and 30 years of non-life nationalisation.

The existing system of distribution of insurance products had left the customer less than satisfied. The various reasons were:

- No choice as to the intermediary channel
- Absence of domain knowledge
- Product not explained at point of sale
- Little or no product innovation
- Product not customised
- Absence of price options
- No involvement of agent in pricing
- Low level of after sales service

There was also the system of direct accounts where the insurers took it upon themselves to service large companies (having paid up capital of over Rs. 10 lakhs as recently amended) and commercial and industrial risks or where government/public sector unit interests were involved. Such risks were treated as direct business for which a special discount in lieu of agency commission was allowed. The clients lost contact with the author of the policy contract, and often learnt a harsh lesson only at the time of a claim.

The authority shifted from the Controller of Insurance to the LIC, GIC and its subsidiaries who issued agency licenses rampantly resulting in an

unmanageable number of licenses agents (12,00,000 of which 8,00,000 in life and 4,00,000 in non-life).

This resulted in the 'silent' minority, 'quality' professionals being painted with the same brush as the vast majority of inadequately trained, inadequately supervised, agents who provided a less than desired level of service to the customer.

With the reversal of the licensing authority to the regulator, this anomaly is well on its way to being rectified and all of us in the profession offer our best wishes and God Speed to IRDA in its monumental task.

Until now the customer has had to face an unequal battle with no one to represent him to the insurer. The new legislation proposes to introduce the insurance broker as an intermediary who would do just that - represent the customer.

The range of his value-added services is like a one-stop insurance supermarket and includes the following:

- Assessing and analysing the client's risk profile
- Finding the best product or products available in the market
- Negotiating the best deal available
- Purchasing for the client the product most suitable for his need
- Continuity of service throughout the period of insurance
- Claims advisory services

The process of converting the single channel system into a multi-channel one needs to be done with an element of caution so as to ensure that the transition is smooth.

This will involve a run off period of re-licensing existing agents as and when their licenses expire and simultaneously licensing applicants as per new norms.

When done, the new channels of distribution of insurance products



could be something like what is in the diagram.

Currently, the system of licensing of individuals as agents has been overhauled with the issue of the agents licensing regulations. Over time this will prune the numbers of those who qualify, and only active agents will remain.

The qualification norms applicable to the promoters of corporate agencies too have been modified by the Insurance (Amendment) Act, 2002, and will expand the variety and number of intermediaries and bring with it substantial employment opportunities.

Insurance broking is an activity distinct from insurance underwriting. It is a sophisticated financial intermediation that serves the customer more than the insurance company.

Until the passage of the IRDA Act, insurance broking was not permitted in India and, consequently, there is no domestic insurance broking industry at present except for a loose system for reinsurance transactions.

However, now that the IRDA has issued the insurance brokers regulations covering both direct and reinsurance brokers, this gap in the functioning of all forms of brokers has also been plugged

The IRDA has recognised the important role that insurance brokers, and other professional insurance intermediaries, play in the development of a modern, competitive and innovative insurance market.

It is in the interest of the insurance market in India, and most particularly the major corporate clients, that a professional and world-class insurance broking industry develops rapidly in India.

The only realistic way in which this will occur is for the international majors to transfer their technology, techniques, training and connections with international insurance markets to India.

Insurance broking is akin to other financial intermediary functions such as investment banking and foreign exchange broking. Indeed, increasingly investment banking and insurance broking are converging as techniques such as Alternative Risk Transfer (ART) are developed.

There is, however, a feeling amongst the international broking community that the brokers regulations, as introduced, have fallen short of the international practice – something that naturally is a matter

of varying opinions and needs to be debated in an atmosphere of frankness and open-mindedness.

There are four main areas of concern.

The first is that the level of foreign direct investment (FDI) is being restricted to 26 per cent unlike other financial intermediaries who are allowed even a majority share upward of 51 per cent. It is, however, recognised that this aspect is something that the IRDA has no control over and therefore as with the rest of the insurance industry, the brokers too would have to wait a while longer.

Section 64VB under which pre-payment of premium is required before an insurer is put on risk is another such area.

As per international broking practices, insurance brokers should be permitted to handle the client's premium and be allowed to transmit it to the insurer net of their brokerage. The regulations as they stand require the comfort of a clarification in this matter on a 'per se' basis and this should not to be left to piecemeal negotiations or sanctions on a case to case basis. This is an area in which diverse opinions exist and, obviously, appropriate safety measures would have to be built into the system.

The practice of allowing a special discount in lieu of agency commission is yet another area of concern since it creates 'an unlicensed intermediary' which is in effect what an insurance

company can become by virtue of the fact that they can market business with the facility of allowing a rebate not perhaps catered for under the tariff regulations. Admittedly, there are contradictory viewpoints on this subject and it should be open to a debate within the insurance industry.

In the code of conduct attaching to the regulations, the potential licensed broker is required to

".... confirm that it has not employed agents or canvassers to bring in business..."

Effectively this restricts a broker from appointing sub-brokers for whom he would have been willing to take responsibility and, I should imagine, the system followed by Securities and Exchange Board of India (SEBI) for sub-brokers in the financial services activity could have been a model for the IRDA to adopt, albeit with suitable modifications to cater to our insurance services.

All of the above observations are my own and are intended to encourage a frank and open debate within the insurance community in order to progress towards stage two of the insurance brokers regulations which will happen in the natural course of time.

Apart from broking, other forms of intermediation and market development initiatives have come into being or will do so soon. These will all find a place in the market and deepen and widen it.

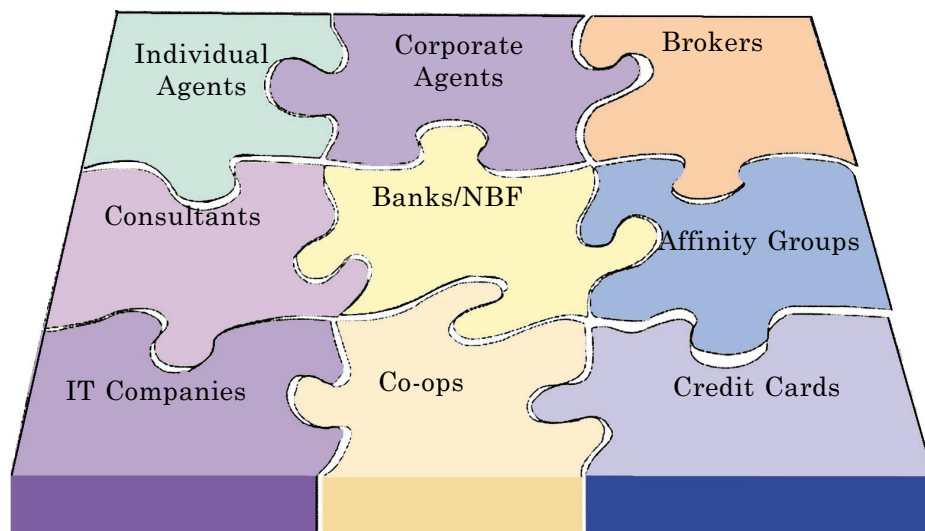
Bancassurance, provided by the widespread banking system, will offer easy accessibility for insurance both in rural and urban areas.

Plastic and electronic payments will open several other channels to market and purchase insurance products.

Co-operatives will play a major role in the development of rural business.

Agents will continue to play a dominant role as the single most preferred representative of the insurer for personal lines of insurance both in life as well as in non-life.

The author is Managing Director, Jardine Lloyd Thompson Insurance Consultants Ltd.



Tariffs Restrict Choice

Peter J. Valentine



Most general insurance is being sold on the Henry Ford principle: "You can have any colour you like as long as it's black".

The main insurance tariff in India is the fire tariff, but there are a number of others as well. A tariff is an agreed rate for something, and in this context, it is the price and terms of an insurance policy that the customer buys to protect himself against an unforeseen event.

In practice, the tariff prevents free negotiation of the terms of a private contract between a buyer and seller of insurance. It is my contention this is neither healthy nor desirable from the

An insurer who says he does not have enough data to rate a risk or that India is somehow different from the rest of the world shouldn't be in the risk business.



point of view of either the insurance provider or the buyer.

The Indian insurance market is now open to competition and around 20 new private companies have entered the market in the past two years. So why should some of these insurance companies agree NOT to compete on either price or extent of cover when selling certain of their products?

Why does this phenomenon affect only general insurance and not life insurance when, prior to liberalisation, there were four companies competing in the general insurance market? There are now twelve general insurers but if the price and cover of a fire policy is the same no matter which insurer you buy it from, how does the buyer decide which company he should give his hard-earned premium to?

Insurers often respond to points like this by saying their service levels differentiate them and it is service quality that the customer is really buying. I agree it is nice to have quick turnaround when a policy is issued but the real test of service is the insurance company's ability and willingness to settle claims fairly and promptly. Most buyers of general insurance products do not usually put this to the test for quite some time, if ever.

Good insurance brokers can soon tell which insurance companies can be recommended, which is of great benefit to commercial and corporate customers who get tailor-made advice from their brokers, but not much help to an individual consumer.

What about reputation, I hear you say? This also differentiates insurers and is an important criterion on which the public will buy a product. But the insurance industry has had a less than acceptable reputation for customer service in India as well as in other countries.

In some respects the problem is worse for the new private insurance companies. How do they in particular convince potential buyers that their products are "better" if they are restricted to offering the same as has been offered by the public sector companies over the past 25 years and at the same price?

It doesn't matter if I am buying insurance on a house or a factory, I come to the same conclusion - the tariff restricts choice. To me it implies that insurers cannot assess or price risks, that innovation is bad, and that although the new insurers are privately, they are happy providing returns to their shareholders based on the lowest common denominator in the market.

I started my career in insurance in the UK as the tariffs were being abolished in the 1970s. We had tariffs for motor, employer's liability,

The Indian consumer is free to buy a wide range of goods and services based on features and on the price that the producer charges. The consumer expects competition on prices for hotel rooms, mobile phone calls and televisions, but if he wants to buy general insurance he will be offered a large number of products not only priced the same, but providing the same features and written in the same, indecipherable, way!

household and fire business – a situation which is not dissimilar to the Indian market in 2002. My understanding is that the UK tariffs were born out of a need to get the rating right when there was not enough spread of risk and there was not enough historical data to price a risk.

I have heard exactly the same arguments put forward in India and neither point is justified. An insurer who says he does not have enough data to rate a risk, or that India is somehow different from the rest of the world, shouldn't be in the risk business. In any case, most underlying rates are driven by re-insurers and a good reinsurance broker will work with the direct insurer and use their international experience to suggest competitive rating structures.

The theme of the CII's 7th Insurance Summit in Hyderabad in November, 2002, was achieving an increase in insurance penetration from 1.50% to 5% of GDP in 3 years. This is not going to happen in the non-life sector unless the tariffs are abolished and a true free market in insurance products is allowed to flourish.

Most non-life premium is generated from a small number of huge risks such as Air India, Hindustan Petroleum Corporation Ltd.(HPCL), Reliance, Bharat Petroleum Corporation Ltd. (BPCL) and Oil and Natural Gas Commission(ONGC). Growth in premium needs to come from the largely uninsured or under-insured Indian businesses that have neither had their risks properly identified nor properly insured.

To finish this piece I quote from an article dated January 7, 2000, in the venerable Post Magazine (one of the oldest insurance publications in the world) which looked back at over a century of developments in UK insurance:

"Tariffs grew like weeds. By 1900 there were at least 60, covering everything from cotton mills to riverside warehouses.

Tariff offices came to control 90% of the market, but the price of consensus was lack of flexibility. It took a long time to get all the offices to agree to changes in premium rates.

Amazingly, tariffs lasted until the 1970s. The motor tariff went first, followed by the employer's liability tariff, the householder's tariff, and finally the fire tariff, which succumbed after an investigation by the Monopolies and Mergers Commission.

Competition from Lloyd's underwriters and non-tariff companies had doomed the tariff system to extinction."

So come on India, stop looking backwards – it is time to develop the skills, knowledge and experience that will support a vibrant and innovative general insurance industry that really responds to the customers' needs. Tariffs do not do that and the sooner they are disbanded the better for both the industry and the customer.

The author is CEO of HSBC Insurance Services and this article reflects his personal views.

E-mail him at peter.valentine@hsbc.com

YOU

just read a fervent plea for detariffing: an issue that raises the passions at any meeting of insurers today.

Is it a hindrance to market development, or a protection in times so bad the general insurance industry has not known much worse? Is it a legacy from the past that needs to be dismantled, or one of those worth preserving?

Or indeed is it something that must go – but slowly.

The focus of our next issue is "Detariffing – Do we need it? Are we ready for it?", and we want to hear what you think.

Write in with your views, experiences and arguments, for or against, in the form of letters, articles or anecdotes to:

The Editor
IRDA Journal
Insurance Regulatory and Development Authority
5-9-58/B, Parisrama Bhavanam, III Floor
Basheer Bagh, Hyderabad – 500 034
Or e-mail us at: irdajournal@irdaonline.org



'A VERY PRECIOUS EXPERIENCE'

It has been an eventful tenure at the Insurance Regulatory and Development Authority (IRDA) for Mr. Hari Om Sonig, Member (Life), who retired on December 31, 2002. He joined the Authority in April 2000, just after the IRDA Act was notified on April 19, 2000. That is, just when the action started in right earnest for the insurance sector!

"In fact when I joined the IRDA, the framework in the field of insurance was obviously at a very nascent stage. The task, therefore, was challenging, but interesting," he recalls.

"It was very rewarding and we derived immense pleasure from working for the right models both for the regulatory system and the insurance industry's operational framework."

The efforts of the regulator and the industry participants have enabled the industry to take strong roots, so much that, despite the not-so-happy economic situation, insurers seem to be enthusiastic about the future, specially in the life sector which is a long term game, he says.

Companies like ICICI Prudential, Max New York Life, HDFC Standard Life and Bajaj Allianz have done really well and this indicates that we have been moving in the right direction.

The most significant achievements in these last two and a half years of the authority's existence, in Mr. Sonig's reckoning, are regulations relating to solvency, investment norms and policyholders' protection. "These have helped create public faith in the system."

Another important landmark is getting the overhaul of insurance legislation going so quickly. The amendment to the Insurance Act done earlier this year was only a small part of job, but once the omnibus legislation for insurance comes, it will revamp the working framework of the entire industry, he says.

Looking forward, Mr. Sonig sees an even more interesting stage in the life

of the Authority and, indeed, the industry.

"From the first stage of registering companies, the regulator now moves into the second stage of regulation and market development and this will be more glorious," he observes. The priorities for this phase – over the next few years – will be development of intermediaries, pension reforms and an emphasis on healthcare products.

Another priority should be to ensure proper grievance redressal machinery within each insurance company so that consumers' needs are taken care of.

In his view what will also become important from the IRDA's side in the next few years is on-site inspections to make sure prescriptions are being followed. This would become significant in the areas of investment, claims settlement, finance and accounts and, very importantly, in containment of management expenses.

Coming as he does from a family of educationists and academics, he has retained his love for learning through his years in the Life Insurance Corporation. He sought voluntary retirement as Executive Director in 2000, and through his working life there, and in the IRDA, this interest in learning and the deep values and ethics his elder brother inculcated in him have been his strength, he reminisces.

Retirement is something he looks forward to, with no specific plans yet but to continue in the insurance industry as a consultant.

Today when he looks back, it is with happiness that the task has been completed smoothly. He says, "the guidance and inspiration provided by Mr. Rangachary was a great source of motivation and strength to me. The support of the office came as a strong back-up for the accomplishment of the task."

"Working for a historic revolution in the insurance industry in India has been a very precious experience for me."

Conference Season!

A *Tripartite Conference on Insurance Frauds* is to be held on January 20 and 21 at Hotel Taj Palace, New Delhi.

The International Association of Insurance Supervisors (IAIS) along with the IRDA will be holding this conference for the benefit of the three sectors – namely insurers, regulators and law enforcement agencies. The Insurance Fraud Committee of the IAIS is directly planning the conference.

Prior to this, the IAIS Committee meeting is to be held from January 16 to 18.

Apart from overseas speakers from the US and UK at the conference, there will be Indian experts as well. The Chief Vigilance Commissioner, Mr R. Shankar, will inaugurate the conference and the Director, Central Bureau of Investigation will speak on anti-money laundering measures. The Joint Commissioner, Delhi Police, will deal with cross border networks and prevention of economic crimes.

Mr R. K. Raghavan, former CBI Director is on the experts committee for the conference and officials from the enforcement directorate will be attending.

With the Indian Parliament having passed the anti-money laundering legislation in the last session, this conference is bound to attract a lot of interest from the targeted participants.

Another conference that is scheduled in Delhi, also for January 20 and 21, is on *Emerging Markets*. This conference will be held jointly by the IRDA, the Institute for Insurance and Risk Management (IIRM), OECD, the IAIS and the Malaysian Insurance Institute (MII).

Two workshops related to motor insurance are scheduled for late January and late February.

On January 27 and 28, the IRDA along with Concert, a Chennai-based centre for consumer education, research, teaching, training and testing, is organising a *National Workshop on Motor Insurance Data and Research* in Hyderabad. Given the background of lack of adequate data for fixing remunerative motor insurance premiums, the workshop will focus on creating a system for collecting and analysing the data for the use of the industry.

Special invitees for the workshop are Dr. Susan Ferguson, Senior Vice President, Insurance Institute for

Highway Safety (IIHS), USA, and Mr. Joseph Carre, Director, National Highway Transport Safety Authority (NHTSA), USA.

The workshop will aim at evolving a concrete plan for a warehouse for motor insurance related data which is to be set up under the IRDA aegis soon.

On February 25 and 26, the IRDA along with Concert will hold a *National Workshop on Safety of Vehicles in India*. The aim of the workshop is to evolve a plan for a vehicle safety and fuel testing centre in Hyderabad which will test and rate vehicle safety, the results of which will have an impact on the insurability and the premium rates each make and model will attract.

There will be special sessions on safety aspects of vehicle design and vehicle types involved in accidents by experts in the respective fields.

Mr. Dave Zubby, Senior Vice President, IIHS, USA, will be a special invitee speaking on the global scenario in automobile safety aspects along with Mr. Clyde Wade, former Research Director, CART, UK.

The Financial Institutions Reform and Expansion (FIRE) Program of USAID is sponsoring the two workshops and their follow up activities.

Fine for Delayed Claims

The Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002, provides for a claim under any insurance policy to be paid or be disputed, giving all the relevant reasons within 30 days from the date of receipt of all relevant papers and clarifications required.

If an insurer causes any delay in this process then he is liable to pay interest at the rate of two percent above the bank rate prevalent at the beginning of the year on the claim amount.

It has come to the attention of the IRDA that insurers, more particularly the public sector insurance companies, have not implemented these provisions.

The operating offices either say they are yet to hear from their reporting offices, or are expecting the IRDA to communicate to them, about bringing into effect the provisions of the regulations.

The IRDA has clarified that the regulations came into effect on April 26, 2002, the day they were gazetted, and no further information or clarification is required for insurers to implement

the provisions of the regulations.

The clarification says, "Already the Authority has been receiving numerous complaints from policyholders pointing out the enormous delay in paying claims which have apparently been accepted, and on which no rejection letters have been issued by the insurers."

"The Authority would like to make it clear that in such circumstances the policyholder is not only entitled to the amount of the claim lodged but also to interest for delayed settlement."

Changes to the India Motor Tariff

The Tariff Advisory Committee (TAC) has announced some amendments to the revised India Motor Tariff effective December 16, 2002.

New depreciation rates for commercial vehicles:

The first of these relates to the rates of depreciation for arriving at the Insured's Declared Value (IDV). The TAC has introduced a new table of depreciation for Motor Trade Policies apart from the existing schedule which will continue to apply for other vehicles.

The Schedule of Depreciation for arriving at IDV for Motor Trade Policies will be as follows:

Age of Vehicle	Depreciation
Not over 6 months	Nil
Over 6 months but not over 1 year	15%
Over 1 year but not over 2 years	20%
Over 2 years but not over 3 years	30%
Over 3 years but not over 4 years	40%
Over 4 years but not over 5 years	50%

No Claim Bonus under the Sunset Clause:

The Sunset Clause protects the No Claim Bonus (NCB) prevailing before the advent of the revised motor tariff on renewal of the policy. This NCB is available if renewal of a policy is done within 90 days of its expiry. That has been amended now to 365 days in the case of military and para-military personnel working in Forward Areas on a case to case basis provided the vehicle was not put to use during the interim period.

Premium for vehicles with bi-fuel kits:

Vehicles with compressed natural gas/liquefied petroleum gas (CNG/LPG) kits in addition to the petrol/diesel system, require a separate insurance cover for such kits. The premium for such kits is charged at 4 % on the value

of the kit. The amendment provides that when such kits are fitted during the currency of a policy the premium can be charged pro rata.

The amendment also states that where the vehicle is fitted only with CNG/LPG kits and their value is not separately available, 5 % extra is to be charged on the Own Damage premium. Rating of vehicles driven by non-conventional sources of power:

For battery operated cars, the rating will be the same as for private cars/taxis up to 1000 cc, and for battery operated motorised two wheelers as per rates applicable for those with capacity exceeding 150 cc but not exceeding 350 cc.

For vehicles driven by any other form of non-conventional energy source the insurer will have to refer to the TAC for rating.

Towing charges for vehicles:

It is now possible to opt for higher towing charges by paying extra premium over and above the limit already provided for under the standard policies.

For private cars a 5 % additional premium can be opted for to avail of towing charges of up to Rs.1,500. For two wheelers, a 5 % additional premium can be paid for towing charges of up to Rs.300.

For commercial vehicles (other than vehicles covered under the Motor Trade Policies) a 5 % additional premium will entitle the insured to towing charges of up to Rs.300 for two wheelers and up to Rs.750 for three wheelers. There is an additional option for three wheelers where the insured can pay 7.5 % additional premium for additional towing charges exceeding Rs.750 but not exceeding Rs.1,500. For taxis a 5 % additional premium will entitle them to towing charges of up to Rs.1,500 and a 7.5 % additional premium will mean towing entitlements of over Rs.1,500 but not exceeding Rs.3,000.

Other commercial vehicles will have to pay 5 % additional premium for towing charges of up to Rs.10,000 and

7.5 % for towing charges of over Rs.10,000 but not over Rs.20,000.

Vehicles covered under Motor Trade Policy can avail towing charges of Rs.300 for 5 % additional premium and over Rs.300 but not over Rs.500 for additional premium of 7.5 %.

Public Grievances Cell

The IRDA has constituted a cell in its office to receive and attend to representations by policyholders on their grievances.

The system of ombudsman has been established in twelve towns and is working reasonably well. Yet there have been some complaints from the members of the public regarding delay in settlement of claims and inattention to their requirements.

The IRDA cannot and does not intend to function as an underwriter. This effort is to look into genuine cases of delay in the settlement of public grievances.

The Public Grievances Cell will consist of :

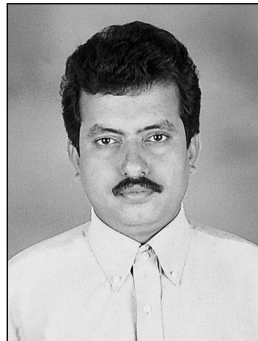
Mr. Prabodh Chander – Executive Director
Mr. Randip Singh Jagpal – Deputy Director
Mr. Anil Kumar Arora – Deputy Director
Ms. Rashmi Jagdeep Abichandani – Assistant Director

Members of the public can represent their grievances to the cell at:

The Insurance Regulatory and Development Authority,
 5-9-58/B, III Floor,
 Parisrama Bhavanam, Basheer Bagh,
 Hyderabad – 500 034.

Systems and Risks

A.R.Nithiyanantham



Insurers and financial institutions have rapidly embraced electronic commerce in recent years as they have sought to lower costs, access a wider

range of customers than is possible through their more traditional means (such as branches) and provide greater flexibility in the services available to customers.

A growing number of insurers and financial institutions now offer a wide range of services through electronic distribution channels. Facilities like viewing premium details of policies and paying for them on-line have been made available to the policyholders. For this purpose insurers have tied-up with various financial institutions and other service providers. Other facilities like calculating premium, tracking a proposal, agent locator, branch locator etc. have also been made available to the public.

With the introduction of these facilities, those buying insurance policies are now able to pay their renewal premiums from the comfort of their desktops through net banking and similar facilities, and to view the details of their policies like policy number, policy date, premium amount, interest amount, gross amount to be paid, instalment number, due date and validity period.

As time goes by, new services on the Internet will be developed and competition will intensify. These developments have the potential to substantially change the way the insurers interact with their customers and with each other. It will also give rise to new areas of risk.

This article addresses prudential issues and risks arising from the

electronic commerce activities in the insurance industry that companies should address in the interest of the customers.

Electronic commerce is broadly defined as the provision of financial products and services through electronic distribution channels.

Even though very few services are now available to the policyholders through electronic distribution channels, it is expected that more facilities are likely to come up as competition intensifies. The ability to view policyholder account details and make payments online could save costs, which could result in lower premiums for consumers in the long term. However the cost of implementing the new technology is significant.

Almost all insurers have an Internet presence with at least a homepage providing institutional information. Some insurers have transactional or interactive websites, which allow customers to pay premium and view policy details on-line, while most of the remaining institutions have only informational websites.

Issues and Risks

Business conducted on the Internet relies on the support of a solid technological framework. Processing and transferring information is accomplished at great speeds.

Data security must be assured and systems must be in place to identify computer viruses and for hacking and intrusion detection.

The cost of properly implementing this technology is great. Companies need to build or acquire the appropriate hardware and software. Some companies do this by outsourcing, but reliance on outsourcing leads to other risks.

Adequate backup and disaster recovery mechanisms should be in

place before e-commerce activities are implemented full-scale.

Strategic Risks

Strategic risks arise when a company, engaging in a new business strategy, does not think through the implications that the decision on electronic commerce will have on other parts of the organisation or the company as a whole. Without a clearly thought out and all encompassing strategic plan, the risk of mistakes occurring increases and the chances of the strategy succeeding decrease.

The decision to engage in e-commerce requires a precise analysis. Some of the points to consider are as follows:

- What the distinctive features of e-commerce are and what the associated operational risks are
- How e-commerce fits with the strategic orientation and the priorities of the company and how it helps achieve those
- Whether e-commerce fits the company's image
- Who will be the target group for this channel of distribution
- What the effect on consumer satisfaction will be
- What implications this new distribution channel will have on traditional business and can the different channels co-exist or be combined, what savings will result and whether the business be profitable
- Whether to develop strategic alliances on the Internet
- What information will be supplied to the consumer

While the Internet may be an efficient way of conducting insurance business, it is far from cost free. In addition to systems costs, establishing and maintaining customer awareness of the website may involve significant advertising costs.

Operational Risks

Operational risks in an e-commerce environment relate to risks that arise as a result of a failure or fault in the information technology infrastructure. An insurance company is prone to operational risks when the application and use of Internet technology is not well managed. The need for know-how and expertise is crucial in this area.

An insurer's information technology infrastructure can be deficient in many ways. For example, it may not:

- have the capacity to handle increased traffic and process transaction volumes
- be scalable (i.e. have the ability to expand or scale down)
- be accessible at all times due to a lack of fault tolerant technology
- be secure from internal and external disruption, or
- be accessible, compatible, or interoperable in every market

Increasingly, as e-commerce expands, companies are outsourcing all or part of their information technology operations. Third party providers are being used to:

- develop websites
- develop insurance-related Internet applications, and
- manage the information technology infrastructure (i.e. hosting servers)

These activities require insurers to have appropriate policies and controls in place to deal with areas such as procurement, contract negotiation and specification and contract management. In addition, they need to be able to assess the service providers' operational viability, financial liquidity and project management skills.

Skilled information technology and project management specialists are also necessary for delivering insurance-related Internet solutions. Companies need skilled staff, in particular skilled resources at their call centres, to support the business processes used by Internet consumers. The increase in

demand and continued restricted supply of skilled personnel will lead to increased costs.

Transaction Risks

A transaction risk is considered to be the risk of any unauthorised alteration or modification to texts, information or data transmitted over computer networks between an insurer and its client, or vice versa. Transaction risk can arise both through e-commerce on-line, and off-line through traditional communication mechanisms.

Transaction risk arises in e-commerce where the source and responsibility for the problem lies in the technology (e.g., with the server that receives and sends data), and not with the insurer or the client. This transaction risk also includes information which is hosted on the server or website of an agent).

When marketing insurance over the Internet, companies must be able to guarantee that, once agreed to, the terms of the insurance contract will not change.

Companies must have sufficiently reliable technical resources to guarantee the integrity of the information and data transmitted over the web. If not, and if consumers realise this risk, the development of Internet insurance marketing will, in the most optimistic scenario, be slowed down.

Transaction risks are closely related to the data security risks and legal risks of insurance companies. If uncontrolled, they can damage both the marketing image of the insurance company and its reputation, particularly when legal conflicts arise between the company and its policyholders.

Data Security Risks

Because e-commerce relies on extensive technological applications and networks, data security risks are significant. Data security risks are considered to be the risks of losses, unintentional changes or leaks of information or data in computer systems.

Data security risks in e-commerce in insurance services can be grouped into two main categories. First, a data security risk is identified within the system of an insurance company. Second, data security risk also arises from intentional or negligent external data breaks. In these cases, for instance, customers' personal data could be accessed illegally by hacking, sniffing etc.

Connectivity risks

Connectivity risk is the risk that a failure in one part of the system may impact other or all parts of the system. It is particularly acute in an electronic commerce environment because the underlying systems are extensive and process data (and, potentially, problems) rapidly. If any part of the Internet's operational system is damaged or modified as a result of negligent or intentional actions, the effects on an insurer's system can be devastating.

There are a number of measures companies can implement, such as contingency, recovery and disaster planning and establishing back-up facilities to minimise these risks. However, many of these measures are complex and need to be executed with care.

It is expected that these risks are being properly identified and addressed within each company depending on their level of involvement in electronic commerce.

The author is Deputy Director (Systems), IRDA.

Discussions (on pension reforms) should stop at this stage and activities should start.

**H. O. Sonig, Member (Life),
IRDA, at CII's
Insurance Summit.**

Streamlining Ombudsmen

One of the primary, physical, consumer protection systems put in place by the IRDA is that of the Insurance Ombudsman. Working for over two years, the system has been activated in twelve cities and has been functioning reasonably well.

The objective of the system is to provide an independent forum to which individual customers of insurance can take their complaints against insurance companies. The Ombudsman system has helped customers develop a faith in the working of the industry as the awards of the Ombudsman are binding on the insurance companies who have to honour them within three months, but not binding on the consumer whose options for recourse to other means of grievance redressal including consumer courts is open.

The Insurance Ombudsman scheme has an inbuilt review mechanism and a committee is to be appointed shortly to look onto streamlining the system.

While the scheme has been doing well overall there have been instances where ombudsmen have exceeded their

powers and passed awards on commercial insurances where they are to confine themselves only to personal lines of insurances and to awards up to Rs. 20 lakhs.

There have also been cases of jurisdictional arbitrage with savvy consumers preferring their complaints with ombudsmen from different jurisdictions than the one under which their case should come logically, due to a pattern of more favourable awards and the like.

Apart from this some meetings of the IRDA and the ombudsmen, whose work is supervised by the former (though they come administratively under the Life and General Councils whose memberships comprise life insurance and general insurance companies respectively), revealed some practical difficulties of running the ombudsmen's offices.

The committee is likely to look into, among other things, a streamlining of the powers of the ombudsmen, defining their jurisdiction and with matters relating to their day to day functioning and its administration.

We welcome...

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

Send your articles to:

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

Insurance Ombudsmen

Mr. M.Venkateshwaran Iyer

Office of Insurance Ombudsman
1st Floor, Universal Insurance Building,
Asaf Ali Road
New Delhi - 110 002

Mr. A. N. Poddar

Office of Insurance Ombudsman
2nd Floor, Shree Jayshree Ambica House,
5, Navyug College
Behind C. U. Shah College,
Ashram Road, Ahmedabad - 380 014

Office of Insurance Ombudsman

1st Floor, 117 Zone 2
Maharana Pratap Nagar
Bhopal - 462 011

Mr. Jagannath Swain

Office of Insurance Ombudsman
62, Forest Park
Bhubaneswar - 751 009

Mr. D. K. Gangopadhyay

Office of Insurance Ombudsman
29, N. S. Road, 3rd Floor
Kolkatta

Office of Insurance Ombudsman

Batra Building shop cum office
101-103, 2nd Floor, Sector 17-D
Chandigarh

Office of Insurance Ombudsman

Fatima Akhtar Court, 4th Floor
312, Anna Salai, Teynampet
Chennai - 600 018

Mr. Achhuttam Unni

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

Mr. S.K. Dhar

Office of Insurance Ombudsman
Aqanus, Bhaskar Nagar
R.G.Baruah Road
Guwahati - 781 021

Mr. C.S.Rao

Office of Insurance Ombudsman
6-2-47, Yeturu Towers
Opp. Saleem Function Palace
A. C. Guards Lakdi-ka-pool
Hyderabad - 500 004

Office of Insurance Ombudsman

Chintal House, 1st Floor
16, Station Road
Lucknow - 226 001

Mr. G. Krishnamurthy

Office of Insurance Ombudsman
101, Arun Chambers
Tardeo Main Road
Mumbai - 400 034

Report Card: Life

A brief analysis of the information furnished by the life insurers for the new business underwritten during the eight month period ending November 2002 in the financial year 2002-03 is given below. As per the proforma prescribed, life insurers have furnished the information under two broad heads, viz., Individual Business and Group Business:

Individual Business

The information was required to be furnished for:

1. Individual new business
2. Single premium new business
3. Individual pension business
4. Individual rural business
5. Single premium rural business
6. Individual rural pension business

Group Business

The information was required to be furnished for:

1. Group insurance business
2. Group gratuity business
3. Group superannuation business
4. Group social sector business
5. Group gratuity social sector business
6. Group superannuation social sector business

The information received from the insurers has since been compiled and an analysis of the same is given below. The data received from the insurers has been categorised into two groups, i.e., private and public insurers.

The private insurers comprised twelve players in the industry (see box item for full list), while the Life Insurance Corporation of India (LIC) was the sole public sector insurer.

The analysis of the data furnished is given below:

INDIVIDUAL BUSINESS

Individual new business

During the first eight month period of the financial year 2002-03, 3,23,579 policies were underwritten for a premium of Rs.23,436.71 lakhs, and sum assured of Rs.8,34,183.01 lakhs, inclusive of riders.

As against this, LIC underwrote 1,04,81,912 policies, against a host of products offered, collecting premium of Rs.2,23,087.45 lakhs, and sum assured of Rs.66,78,422 lakhs. The maximum policies were underwritten under the Endowment plan, followed by the Money Back Plan, being 66,45,675 policies and 31,79,783 policies,

respectively. The premium underwritten under the two plans were Rs.13,47,81.7 lakhs and Rs.7,35,85.93 lakhs, respectively.

During the month of November, the private players have shown an increase of 21.73% over the premium collected up to the previous month. During the same period LIC has shown an increase of 19.60%.

Single premium new business

During the period up to the month of November 2002, the private players offered a host of products under single premium policies. During the eight month period 18,347 policies were underwritten by the private players garnering premium of Rs.17,216.57 lakhs, and sum assured of Rs.26,488.22 lakhs.

As against this, LIC underwrote 2,09,435 policies at a premium of Rs.1,92,357.42 lakhs, and sum assured of Rs.2,32,332 lakhs. Maximum business was underwritten under the 'Others' category at 1,78,883 policies and premium underwritten of Rs.1,66,084.18 lakhs, followed by Endowment plan at 30,155 policies and premium underwritten of Rs.26,52.24 lakhs.

During the month of November, the private players have shown an increase of 10.22% over the premium collected up to the previous month. During the same period LIC has shown an increase of 10.34%.

Individual pension business

Under the individual pension business, the private players offered single and regular premium policies and personal pension plans. A total of 24,442 policies were underwritten at the premium of Rs.3,261.99 lakhs.

As against the private players, LIC underwrote 29,314 policies for a premium of Rs.6,345.08 lakhs.

During the month of November, the private players have shown an increase of 15.40% over the premium collected up to the previous month. During the same period LIC has shown an increase of 27.42% in the premium underwritten.

Individual rural business

The private players underwrote a total of 18,328 policies for a premium of Rs.304.28 lakhs, and sum assured of Rs.9,131.7 lakhs. Maximum premium was underwritten for endowment plan at Rs.225.07 lakhs, followed by money back plan at Rs.51.12 lakhs. Linked policies were also underwritten.

As against the private players, LIC underwrote 24,39,905 policies in the rural sector, with premium amount of Rs.40,012.8 lakhs and sum assured of Rs.11,94,597.68

lakhs. Maximum policies were underwritten for the endowment plan at 16,03,127 policies at a premium of Rs.23,449.56 lakhs, followed by Money back Plan at 7,31,586 policies at a premium of Rs.15,106.02 lakhs. Under the unit-linked plan, one policy was underwritten.

During the month of November, the private players have shown growth of 17.46% over the premium collected up to the previous month. During the same period LIC has shown an increase of 23.70%.

Single premium rural business

A number of products were offered to the rural sector for single premium business, by both the private and public insurers. Private players wrote 3,172 policies in the rural sector for a premium of Rs.30.01 lakhs and sum assured of Rs.332.9 lakhs.

LIC underwrote 9,225 policies for a premium of Rs.5,187.53 lakhs and sum assured of Rs.6,406.61 lakhs during the period ended November 2002. The maximum number of policies was underwritten under the "Others" category at 7,811 policies, and premium underwritten of Rs.4,312.27 lakhs. No policy was underwritten under the Unit linked single premium rural business.

During the month of November, the private players have shown an increase of 82.32% over the premium collected up to the previous month. During the same period LIC has shown an increase of 18.61%.

Individual rural pension business

Under the individual pension business for the rural sector, 230 policies were underwritten by the private insurers with premium underwritten of Rs.58.5 lakhs.

LIC underwrote 843 individual pension policies in the rural sector for a premium of Rs.143.54 lakhs during the period under reporting.

During the month of November, the private players have shown an increase of 7.58% over the premium collected up to the previous month. During the same period LIC has shown an increase of 29.87%.

GROUP BUSINESS

Group insurance business

The private players offered over 228 schemes under group insurance business during the first eight months of the financial year, covering 2,71,822 lives. The premium underwritten during the period was Rs.1,380.76 lakhs.

LIC offered the Term and the Group Savings Linked Insurance schemes during the period. Under these two options, 3,507

schemes were underwritten covering 7,58,164 lives. The premium underwritten was Rs.1,784.04 lakhs.

During the month of November, the private players have shown an increase of 25.32% over the premium collected up to the previous month. During the same period LIC has shown an increase of 13.46%.

Group gratuity business

The private players were operating ten schemes during the year, covering 1,151 lives. Premium underwritten during the period was Rs.211.08 lakhs.

As against this, LIC offered 964 schemes during the period covering 1,25,744 lives. New business premium underwritten during the period was Rs.17,341.75 lakhs. This includes Group Leave Encashment Business also.

During the month of November, the private players have shown an increase of 3.70% over the premium collected up to the previous month of the current year. During the same period LIC has shown an increase of 11.05%.

Group superannuation business

Under seven different schemes offered by the private players, 606 lives were covered, and Rs.489.8 lakhs premium was underwritten during April to November, 2002.

LIC offered three products under group superannuation, namely Group Superannuation (GS), Group Annuity (GA) and VRS, covering 157 schemes. 24,701 lives were covered under the schemes, and Rs.46,288.95 lakhs premium was underwritten during the first eight months period of the current financial year.

During the month of November, the private players have shown an increase of 5.83% over the premium collected up to the previous month. During the same period LIC has shown an increase of 10.79%.

Group social sector business

Private players offered 9 schemes, covering 16,614 lives under the social sector, and garnered Rs.7.89 lakhs.

As against this under the Janashree Bima Yojana, LIC offered 1,744 schemes, covering 2,30,660 lives, and underwrote premium of Rs.230.66 lakhs. As a rider, under the Shiksha Sahayog Yojana 16,743 lives were covered for a premium of Rs.51.71 lakhs.

During the month of November, the private players have shown an increase of 249.12% over the premium collected up to the previous month. During the same period LIC has shown an increase of 13.22%.

Group gratuity social sector business

None of the players – private or public, reported any business during the eight month period.

Group superannuation social sector business

None of the private players reported any business during the period.

During the first eight months of the current financial year, 2,140 term and savings related schemes were offered to cover 80,007 lives with underwritten premium of Rs.136.03 lakhs.

New business done in the first eight months of 2002-2003

(Rs. in lakhs)

Individual Business	Premium	Policies	Sum Assured
Individual new business	246524.15	10805491	7512605.01
Single premium new business	209574.02	227782	258820.22
Individual pension business	9607.07	53756	
Individual rural business	40317.08	2458233	1203729.38
Single premium rural business	5217.54	12397	6739.51
Individual pension business - rural	202.04	1073	
TOTAL - Individual business	465705.24	11087029	7771425.23

(Rs. in lakhs)

Group Business	Premium	Schemes	Lives
Group insurance business	3164.8	3735	1029986
Group gratuity business	17552.83	974	126895
Group superannuation business	46778.75	164	25307
Group insurance - social sector business	290.26	1753	264017
Group gratuity - social sector business			
Group superannuation - social sector business	136.03	2140	80007
TOTAL - Group business	67496.38	4873	1182188

Report Card: General

Analysis of the non-life business figures for the eight months ended November, 2002

As on November 30, 2002, there were twelve companies underwriting business in the non-life insurance sector. Of these four are public sector companies, viz. National Insurance, New India Assurance, United India and Oriental. In the private sector, eight companies underwrote business viz. Royal Sundaram, Tata AIG, Reliance, IFFCO-Tokio, ICICI Lombard, Bajaj Allianz, Cholamandalam and HDFC Chubb. Of these, the last two commenced operations in October 2002.

An analysis of the information furnished by the insurers reveals that the four public sector companies have underwritten business to the extent of approximately 91% of the total premium underwritten in the eight month period of the financial year 2002-03. The private sector accounts for 9.07% of the premium underwritten.

Further analysis of the performance of the private players reveals that fire business accounts for the maximum business underwritten at Rs. 26,731.58 lakhs of the business by them, followed by motor business at Rs. 22,209 lakh.

The engineering business accounted for Rs.8,321 lakhs with marine (cargo and hull) and health segments following at Rs.4,881.24 lakhs and Rs.4,679.28 lakhs respectively.

These five segments cumulatively accounted for approximately 81% of the business underwritten by the private players.

On account of non-availability of break up of the premium underwritten by the public sector players, similar segment wise analysis is not possible for the public sector.

However a study of the business figures furnished by Oriental reveals that maximum business was underwritten in the motor segment at Rs.66,396.86 lakhs followed by fire at Rs.40,484.85 lakhs.

New business done in the first eight months of 2002-2003

(Rs. in lakhs)

S. No	Insurer	Premium Underwritten	No. of Policies Issued
1	Royal Sundaram		
	Fire	2681.92	9078
	Marine-Cargo	805.49	1277
	Engg	1034.90	278
	Motor	4863.69	115700
	Health	595.06	10341
	Liability	61.82	170
	Personal Acc	1257.40	20418
	Others*	370.39	2806
	TOTAL	11670.67	160068
2	Tata AIG		
	Fire	2477.08	2670
	Marine-Cargo	1591.48	1708
	Engg	2216.96	449
	Motor	4894.05	51692
	Health	2263.96	64896
	Liability	1361.02	168
	Others	43.17	1898
	TOTAL	14847.70	123481
3	Reliance		
	Fire	3788.52	2885
	Marine Cargo	352.03	2003
	Marine Hull	31.78	0
	Engineering	869.46	575
	Motor	419.59	7391
	Health	334.06	421
	Aviation	364.88	40
	Liability	1257.23	491
	Marine Energy	4527.51	3
	Other Miscellaneous	685.13	2804
	TOTAL	12630.19	16613
4	IFFCO-Tokio		
	Fire	7719.51	6319
	Marine Cargo	838.40	5262
	Marine Hull	346.91	16
	Engineering	1536.75	838
	Motor	1334.50	63206
	Health	549.98	8340
	Liability	222.08	524
	Sankat Haran	716.22	1757
	Others+PA	868.49	5265
	TOTAL	14132.85	91527
5	New India*	249873.00	N/A

The aviation and health segments accounted for Rs.16,706.66 lakhs and

Rs.13,487 lakhs of the premium underwritten respectively.

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(Rs. in lakhs)			
S. No	Insurer	Premium Underwritten	No. of Policies Issued
6	Oriental		
	Fire	40484.85	423293
	Marine Cargo	9084.68	107249
	Marine Hull	4845.66	3812
	Engineering	10599.99	31486
	Motor	66396.86	2999325
	Health	13487.02	231404
	Aviation	16706.66	868
	Others	26126.38	1011754
	TOTAL	187732.10	4809191
7	National*	186059.00	N/A
8	United India*	203991.00	N/A
9	ICICI -Lombard		
	Fire	7299.23	18533
	Marine Cargo	317.39	338
	Marine Hull	154.34	4
	Engg	1222.64	388
	Motor	55.70	747
	Health	513.01	48
	Aviation	75.69	8
	Liability	62.24	45
	Special Contingency	10.22	13
	Others	1483.88	18301
	TOTAL	11194.32	38425
10	Bajaj Allianz		
	Fire	2675.63	9873
	IAR	822.67	444
	Cargo	440.51	4295
	Motor	10491.85	435827
	Engg	1316.25	1091
	Health	421.23	7409
	Aviation	57.17	10
	Travel	610.13	46726
	Special Contingency	213.98	427
	Misc.	637.80	16266
	TOTAL	17687.22	522368
11	Cholamandalam		
	Fire	89.70	142
	Cargo	2.91	8
	Engg	124.10	4
	Motor	26.06	942
	Health	1.99	32
	Liability	6.16	3
	Others	1.72	78
	TOTAL	252.64	1209
12	HDFC Chubb		
	Motor	123.82	1399
	TOTAL	123.82	1399
	GRAND TOTAL	910194.50	5764281#

N/A : Not available

*Break-up not available

Does not include number of policies for New India, National, United India, Cholamandalam and HDFC Chubb began their operations in October 2002.

The National Insurance Academy library is a specialised one with over 20,000 documents, 180 journals and non-print material like audios/ videos and a special collection of CDs, called the C.D. Deshmukh Digital Library.

The library has Internet browsing facilities, reference, photocopying and bibliographic services. Participating in any NIA training programme will enable you to avail of all these facilities.

Consultancy and training in development and upgradation of insurance library automation, library administration and management, documentation and circulation of library material is provided to insurance companies and small libraries. Module-wise training for different requirements is conducted on demand.

NIA library is now extending library services outside the library building. The 'Library Outside Library Building' Project has the following components:

- Jagdishchandra Bose Library: A nature library.
- Issac Newton Library: Science library where reference material will be displayed like encyclopaedias, pictorial informative books and insurance event maps.
- Tukaram Library: Music library where musical instruments (ancient and modern) will be stored and displayed.
- Mahalonobis Library: All actuarial products will be displayed preferably with computer animation.

The NIA library publishes monthly issues of 'Current Awareness List' with bibliographic details of the articles published in journals received by it. The annual subscription for the list is Rs. 300/- for hard copy and Rs. 250/- for soft copy.

For details, Contact:

Mrs. B.J.Sane

Librarian

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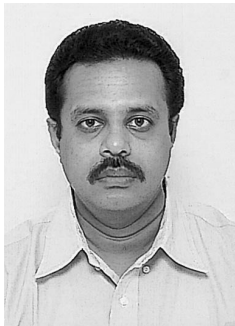
Fax: 020-7292392

e-mail: bjsane@niapune.com

Securitised Assets

S.N.Jayasimhan

An investment opportunity



In recent times the most prominent developments in international finance and the one that is likely to assume even greater importance in future is

securitisation.

Securitisation is the process of pooling and repackaging of homogenous, illiquid, financial assets into marketable securities that can be sold to investors. The process leads to the creation of financial instruments that represent ownership interest in, or are secured by, a segregated income-producing asset or pool of assets. The pool of assets collateralises securities. These assets are generally secured by personal or corporate loans or by real property (like automobiles, real estate, or equipment), but in some cases are unsecured (as in credit card debts and consumer loans).

A typical securitisation programme involves various steps. They are:

1. A special purpose vehicle (SPV) is created to hold title to assets underlying the securities
2. The originator or holder of assets sells the assets (existing or future) to the SPV
3. The SPV, with the help of an investment banker, issues securities which are distributed to investors
4. The SPV pays the originator for the assets with the proceeds from the sale of securities

The touchstones of Securitisation are

- Legal true sale of assets to an SPV with narrowly defined purposes and activities
- Issuance of securities by the SPV to the investors collateralised by the underlying assets

- Reliance by the investors on the performance of the assets for repayment – rather than the credit of their originator (the seller) or the issuer (the SPV)

- Consequent to the above, “bankruptcy remoteness” from the originator

Apart from the above, the following additional characteristics are generally noticed:

- Support for timely interest and principal repayments in the form of suitable credit enhancements

Securitisation is the process of pooling and repackaging of homogenous, illiquid, financial assets into marketable securities that can be sold to investors.



- Formal rating from one or more rating agencies

There are primarily three parties to a securitisation deal, namely:

The originator

This is the entity on whose books the assets to be securitised exist. It is the prime mover of the deal in that it sets up the necessary structures to execute the deal. It sells the assets on its books and receives the funds generated from such sale. As such the originator transfers both the legal and the beneficial interest in the assets to the SPV.

The SPV

The issuer, also known as the SPV is the entity which would typically buy the assets (to be securitised) from the originator. As one of the main objectives of securitisation is to remove the assets from the balance sheet of the originator, the SPV plays a very

important role in as much as it holds the assets in its books and makes the up-front payment to the originator.

The investor

The investors may be in the form of individuals or institutional investors like financial institutions (FIs), mutual funds, provident funds, pension funds, insurance companies and the like. They buy a participating interest in the total pool of receivables and receive their payment in the form of interest and principal as per the agreed pattern.

Besides these three primary parties, the other parties involved in the securitisation deal are given below:

The obligor

The obligor is the originator's debtor (borrower of the original loan). The amount outstanding from the obligor is the asset that is transferred to the SPV. The credit standing of the obligor is of paramount in a securitisation transaction.

The rating agency

Since the investors take on the risk of the asset pool rather than that of the originator, an external credit rating plays an important role.

The rating process would assess the strength of the cash flow and the mechanism designed to ensure full and timely payment by the process of selection of loans of appropriate credit quality, the extent of credit and liquidity support provided and the strength of the legal framework.

Administrator or servicer

It collects the payment due from the obligor and passes it to the SPV, follows up with delinquent borrowers and pursues legal remedies available against the defaulting borrowers. Since it receives the installments and pays it to the SPV, it is also called the Receiving and Paying Agent.

Agent and trustee

It accepts the responsibility for overseeing that all the parties to the securitisation deal perform in

accordance with the securitisation trust agreement. Basically, it is appointed to look after the interest of the investors.

Structurer

Normally, an investment banker is responsible as structurer for bringing together the originator, credit enhancer(s), the investors and other partners to a securitisation deal. It also works with the originator and helps in structuring deals.

The different parties to a securitisation deal have very different roles to play. The entire process is broken up into separate parts with different parties specialising in origination of loans, raising funds from the capital markets, servicing of loans etc. It is this kind of segmentation of market roles that introduces several efficiencies that securitisation is so often credited with.

Advantages of structured products

- Attractive yields compared to similar rated corporate bonds
- They usually secure a AAA credit rating from recognised rating agencies
- They are less sensitive to dramatic market events
- From a credit standpoint Asset Backed Securities (ABS) investments are very secure. Ratings are assigned on the basis of the strength of the underlying collateral and the legal structure in place
- The diversity offered to investors to move away from the traditional concentrations in government securities and money market instruments and at the same time not compromising on credit quality
- Credit ratings are studied universally by the level of their stability and the prospect of possible upgrade or downgrade. In the case of structured finance transactions credit ratings assume greater importance because of the inherent comparison between them and

corporate paper in the comparable rating spectrum.

- Structured finance ratings tend to exhibit less volatility when compared to plain corporate debt. The logic behind a structured finance rating being more stable is that in the case of an ABS, whilst initiating a rating, the rating agency studies the underlying cash flows and the strength of the structure. It also analyses the strength of the underlying obligors and the diversification in the pool as well as the strength of the legal structure.

As in any financial investment, there are inherent risks in

— ■ —
The opportunity
becomes even more
attractive in the context
of a dearth of investments
with the rating to qualify
as approved investments.



securitisation deals as well. They can be classified as follows:

Bankruptcy/ performance risk

Since securitisation relies on the future generation of cashflow to repay investors, the continued existence and performance of the borrower throughout the tenure of the transaction are critical consideration to investors. Indeed, this risk generally acts as the limiting constraint on the rating of the transaction and consequently determines the tenure as well as the pricing.

If the borrower becomes insolvent, no creditors of the borrower would be able to make a claim against the receivables sold to investors. So long as the borrower continues to operate (even in bankruptcy), investors will receive payments on the receivables on time and unhindered. In terms of mitigating this risk, there is very little that can be done structurally.

Generation risk

There is yet another risk related to the sustained generation of the receivables which are outside of the control of the borrower. That is, reserves may not materialise or seasonal variations in the anticipated levels of receivables may occur. This risk is mitigated through adequate over-collateralisation.

Price risk and off-take risk

These refer to likely price variations or the concern that the obligors in the future cease buying their purchasing level of the goods or service from the seller.

IRDA and securitisation as an investment

IRDA has not yet considered securitised assets as an eligible investment for insurers. However, as per the IRDA regulations, secured instruments with a minimum rating of AA are classified as approved instruments. The opportunity becomes even more attractive in the context of the present economic scenario of the country as there is a dearth of good investment opportunities, especially for investments in the rating bucket qualified for approved investments.

The Reserve Bank of India (RBI) has allowed lower risk weightage to investment in mortgage-based securities (MBS) by banks. It has also allowed such investments to be treated as priority sector investment subject to certain conditions. Thus, it may be observed that RBI is trying to promote such investments by banks.

In view of this the IRDA could also think of allowing securitised instruments meeting a minimum rating of AA and secured, as per IRDA (Investment) Regulations, to be considered as an eligible investment after weighing the risks involved.

The author is Deputy Director, IRDA.

First year of Segment Reporting

R. Anand



Accounting Standard (AS) 17, the Accounting Standard on Segment Reporting is one of the more important of the new generation accounting

standards released by the Institute of Chartered Accountants of India (ICAI). This mandatory standard comes into effect in respect of accounting periods commencing on or after April 1, 2001. It is applicable to all enterprises whose equity or debt securities are listed on a recognised stock exchange and enterprises that are in the process of issuing equity or debt securities that will be listed on a recognised stock exchange.

For other business enterprises, this standard is applicable where the turnover for the accounting period exceeds Rs.50 crores. Over the years, there has been a grievance from users of financial statements that Indian companies were not disclosing segment-wise or division-wise performance in an understandable manner to the world at large. There was a feeling that the inefficiencies of one segment / division were hidden by substantial profits made by other segments / divisions. This was particularly true in the case of large enterprises which have many products and divisions.

The first year of application of this standard, the year ended March 31, 2002, has been a mixed bag. While some companies have disclosed elaborate segment information, certain other companies have more or less bypassed disclosure.

The fundamental feature of AS 17 is to identify and disclose the distinguishable components of a business segment. This is accomplished by way of segregating identifiable products, services or activities, as the case may be. Clear-cut guidelines and rules are laid down

in AS 17 for determining business segments.

Similarly, there is a requirement to identify geographical segments based on specific criteria. One criterion to determine geographical segment is that risks and returns should be different within a particular economic environment. Several companies have taken the stand that India as a whole constitutes one geographical segment.

AS 17 has specific application and requirements for the general insurance business. The principles of AS 17 have to be applied in the context of The Insurance Regulatory and Development Authority (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002. In these regulations, it is stated that:

- (a) *Accounting Standard 17 (AS 17) - Segment Reporting - shall apply to all insurers irrespective of the requirements regarding listing and turnover mentioned therein.*
- (b) *An insurer shall prepare the Revenue Account, Profit and Loss Account (Shareholders' Account) and the Balance Sheet in Form B-PL, and Form B-BS, or as near thereto as the circumstances permit.*

Provided that an insurer shall prepare Revenue Accounts separately for fire, marine and miscellaneous insurance business and separate schedules shall be prepared for Marine Cargo, Marine - Other than Marine Cargo and the following classes of miscellaneous insurance business under miscellaneous insurance and accordingly application of AS 17 - Segment Reporting - shall stand modified.

1. Motor 2. Workmen's Compensation / Employers' Liability 3. Public / Product Liability 4. Engineering 5. Aviation 6. Personal Accident 7. Health Insurance 8. Others.

The regulation itself has laid down the basis on which segment information has to be prepared across the general insurance industry. This is not only welcome but appropriate since it would facilitate easy comparison across companies operating in the same industry. Further, product-wise demarcation is already contained in the Insurance Act, 1938, which has stood the test of time. Most general insurance

companies have identified business segments in accordance with the regulations. As far as geographical segment is concerned, the stand taken is that India constitutes one geographical segment and outside India is a different geographical segment.

In implementing AS 17 for general insurance business, the following problem areas were encountered in the first year of its application.

1. How do we determine "turnover" for a general insurance business? Is it Gross Written Premium (GWP), Net Written Premium (NWP) or Net Earned Premium (NEP)? Also, is investment income part of "turnover" for this purpose?
2. Will segment revenue for this purpose mean Gross Written Premium, Net Written Premium or Net Earned Premium?
3. How do we allocate various expenses of management to the appropriate business segments?
4. How do we disclose claims with reference to various business segments? Can gross claims be shown as actual part of segment information and the recovery of such claims shown separately as part of segment revenue? Or can claims on a net basis alone be reflected as part of the business segment.

The issues raised above represent only the tip of the iceberg. As we move along, there will be more areas requiring attention and clarification in the matter of segment reporting. The first year was the learning period for industry in general and the general insurance industry in particular.

It will be ideal if IRDA prescribes a typical model for this business in the matter of segment reporting drawing from the disclosures and experience of the first year. This model can be used as the basis or as best practice to be adopted in the years to come.

The author is General Manager, Corporate Affairs, Sundaram Finance Limited. The views expressed here are his own.

Unhealthy & Indifferent about it

K.Nitya Kalyani

Worth over Rs.86,000 crores and expected to grow by 8,000 crores each year.

That was what the healthcare and health financing industry was estimated at by various consultants and research units a few years ago. Yet, no one seems too eager to bite a piece off it. Not yet.

It seems paradoxical specially when the industry is non-cyclical and virtually immune to recession. We all fall sick all the time and, even if bonuses are being cut, we take ourselves and our children to the doctor. The need is universal and the universe is indeed huge in a country like India.

Then what ails the healthcare financing dream? Why is it not taking off? Why is health insurance still a mirage out here?

Too many years ago that I don't care to count now, I joined New India Assurance Company as a clueless new recruit and the tedium of public sector working life was all apparent.

But there was sudden excitement in the air! A new policy was going to be introduced and people stood in groups in our offices talking about it and awaiting details and documentation from the head office!

New India, and indeed the three other general insurance companies, was going to launch Mediclaim! It was a medical policy - a hospitalisation indemnity policy to be precise - and must have been the first personal line product to be launched in years! And it even had a brand name! It stood out in shining glory amongst the dusty old Fire Policy 'A's and marine floating policies.

What's more, it was fashioned in double quick time and launched following the then Prime Minister, Rajiv Gandhi's, announcement in Parliament that the people would soon have health insurance.

As these things go, that announcement was the first anyone in

the insurance industry had heard of all this. Launched it was, and with the embellishment of a tax deduction on the premium, to encourage people to buy it.

And again, as things go, there are many who wish that was the last they had heard of it. Not that the aspirations of the Prime Minister, who regarded health as a technology mission, were wrong. But mandated products have unique but strange cycles which Mediclaim also followed.

And here is how it happened, through the eyes of the same bewildered recruit of New India.

The product came with its table of rates and minimal variants, as products then were wont to, and customers started trickling in, usually towards the end of the financial year due to the tax break.

There were structural problems with the product including inflexible coverage terms, but then there was no other product like it in the market and so it moved.

With minimal variants the premium on an individual policy was too small and so too was the sales commission on it. So it was hardly the agents' favourite policy in a world where agents sold you only policies that they wanted to sell at all - a fact more apparent in life insurance over the decades. In fact, if you were a pretty good salesman you could get an agent to issue you a Mediclaim!

But customer dissatisfaction rose like a wave. It was when they made claims that they suddenly realised that this was not a medical policy, but would pay only if you went to hospital - and not for common colds and flu attacks - and then too only under certain terms and conditions.

Exclusions, pre-existing conditions and claims denials set off angry letters to newspaper editors and litigations at consumer courts that the industry had just not bargained for and about a product that they increasingly did not want to even speak of.

In fact pretty soon Mediclaim was

issued only to corporate customers as group cover and even then only as 'accommodation business' - which is when a client is giving the insurer too much other business for the latter to say 'no' to some bad business.

What other Mediclaim sold was equally because of the tax rebates, but ironically, it was the tax rebate that turned out to be a constraint later.

But before that was the biggest blow. And there is no kinder word to describe it than fraud.

Sheer manipulation and fraud involving individual patients, doctors and even large hospitals.

What they simply did in collusion was to conjure up or magnify illnesses, hide pre-existing conditions, charge higher fees and request more and sometimes unnecessary diagnostic tests and procedures when Mediclaim was in the picture. Indeed Mediclaim was even bought to cater to a surgery ready to be done, or ready to be faked as well.

In the face of such sheer misuse and exploitation - even by big name hospitals - the industry went into shock. New India was happy to pass on a prestigious group Mediclaim policy with huge premiums to United India by discouraging the client by loading the premium at renewal.

It is another story that United India in turn passed the parcel that went around to all four companies in due course!

These problems happened because the health sector was hardly organised or accountable in its ways, a problem that has only blown to mammoth proportions today with many more doctors and hospitals.

There were no standardised rates, the insurance industry had minimal knowledge of treatments and diseases and relied on panel doctors for the domain knowledge rather than recruiting and developing in house expertise (they recruited veterinarians for rural business but...) What is more there is no reliable medical history system in the country. There is no way

for you to find out, for instance, whether I have had a stroke unless I told you, and that is no way for health to be underwritten.

Claims ratios hit the roof, but it is still possible to convert that into profitable business. But the response of increasing premiums and rationalising cover, and introducing variants with value adds were crushed in one stroke when the Central Board of Direct Taxes (CBDT) decided that the tax break would only apply for premiums up to Rs.1,500 or so – which was the price of a basic policy when introduced.

So the industry desisted for a long time from improving a product and pulling it out of the mire, and the customer lost the opportunity for wider coverage, albeit at a higher price. The industry was just scared off the product for a long time and the market never got the health insurance that it deserved. And the tragedy of Indian health insurance was that Mediclaim has been for too long synonymous with health insurance.

The problem cannot be ignored for too long and socially, financially and in terms of business opportunity health

insurance should be made to happen, and soon.

We present in the following pages an introduction to the issues in health insurance and the health sector itself in India including extracts of two recent reports on what ails these sectors and recommendations on what can be done.

This is IRDA Journal's first step towards kicking off an industry wide debate and we will keep the forum open for discussion from you for the next few issues.

The CII-McKinsey Study

The CII-McKinsey combine's report is on the healthcare sector and touches upon healthcare financing and insurance significantly.

The key points of the study are:

The Government should stimulate the growth of private, social and community insurance to improve affordability. For this it should:

In private insurance

- Recognise health insurance as a separate line of business
- Reduce capital requirement for health insurers from Rs. 100 crores to Rs. 30 to 50 crores
- Introduce capital monitoring and product level norms for private health insurers

In social insurance

- Separate the roles of the Employee State Insurance Scheme (ESIS) as payor and provider to create a credible social insurance system
- Mandate all formal sector employers to provide health insurance (either social or private)

In community insurance

- Create national guidelines
- Set up pilots in 1 or 2 states and monitor existing schemes

Health insurance has the highest level of risk among the different types of insurance

- Life insurance does not require strong underwriting skills as death is a certain event, so management of investments is more important
- Underwriting is critical in general insurance as the event is uncertain but the payout is known so the key to success is targeted products to attractive segments through strong underwriting and claims management.
- In health insurance the probability of payout is uncertain and so is the amount payable. So health insurers have to offer products for specific treatments to profitable segments, control costs by managing or controlling hospitals and through strong underwriting and claims management.

Health insurance is also a low-margin, high volume business.

A typical, viable private health insurer will have a 3 per cent operating margin after claims, marketing and administrative expenses. But in India the claims alone account for 120 to 130 per cent of premium and investment incomes put together and hence the business is unattractive.

Because of this, the Rs.100 crores entry capital plus risk-based solvency norms means that the business has to grow at 55 per cent for 15 years to break even assuming doubling of existing premia and assuming a starting claims ratio of 90 per cent reducing to 85 per cent in 5 years.

The report says that without regulatory change health insurance penetration will remain static with insurance covering the wealthier parts of the society alone.

The lowering of entry capital is imperative and the stability of the business, and hence consumer interests, will be protected by introducing and monitoring risk-based solvency norms.

Universal health coverage can be reached with mandated insurance in urban areas and high public subsidies in rural areas.

The healthcare industry should create and adopt quality standards for healthcare delivery and work with insurers to grow insurance by developing treatment protocols, defining standards for data requirements, developing risk sharing models with insurers and making patient flows efficient by developing hub and spoke models to avoid overcrowding and 'over treatment' at expensive facilities.

The Sub-group Report

The report of sub-group on health insurance constituted by the Ministry of Health and Family Welfare has put forth various analyses and recommendations. Extracts:

The indemnity insurance market in India is high claim driven and there is a mismatch between risk coverage and premium.

- Multi-tiered health insurers should be encouraged. State level or regional players may have greater access to, and understanding of, local needs.
- Healthcare providers should be encouraged to establish and run managed care schemes, subject to the minimum capital and solvency norms.
- New players should be created and regulated with a not too stringent minimum capital requirement but one based on the risk-based capital norms.

Why global players have not entered the market:

- Rs. 100 crore entry capital makes a health insurance venture unviable and unattractive given the existing market size and the projected slow organic growth.
- Distortion in the balance between price adequacy and coverage in the 'Mediclaim' policy which is the benchmark product. The product is loss-making but competitors are under pressure to match it till it exists.
- The standard 20 per cent cession to GIC, the national reinsurer is not needed for health insurance, which is a steady business, and cession reduces margins.

New players needed in the market include:

Third Party Administrators (TPAs) can be the one-stop shop for managing the health of employees across companies. They tie up with hospitals and diagnostic centres for this.

Preferred Provider Organisations (PPOs) provide medical services to corporate members and process insurance claims.

Health Maintenance Organisations (HMOs) can do all the above and also carry the risk. TPAs and PPOs are likely to convert themselves into HMOs.

The IRDA should develop specific regulations for the health insurance players. It may also be necessary to insist on a professional indemnity policy for the players.

Insurance schemes that can cater to the different segments of the population should be introduced and encouraged. All health insurance or quasi health insurance schemes operated by all entities including non-government organisations (NGOs) also need to be registered with the IRDA, and regulated and monitored by it.

There is a need for one comprehensive insurance product which also covers pre-existing diseases.

Incentives for health insurance participation should continue and be increased.

The Government should:

- Introduce rating and credentialling of the providers
- Create common standards and norms for coding of diseases and treatment procedures
- Adopt standard health codes
- Create an information bank on insurance, diseases and treatment
- Ensure portability across players and schemes
- Encourage community initiatives in healthcare financing

Appropriate Regulation

The IRDA should be aware of and resolve the potential issues of excess usage of health facilities, increase in inappropriate care, adverse selection and risk selection that go with the availability of health insurance, and their implications for the standard goals of health policy.

Health insurance is one of the most regulated forms of insurance business in countries where it plays a dominant role in financing of health expenditures. The reasons are:

- Vital need to protect insureds
- Variety of benefits
- Multiple claims
- Difficulty in ascertaining the nature of loss
- Increasing healthcare costs
- Changing technology
- Non-uniform policy provisions
- Multiplicity of health financiers

Exhaustive regulations to oversee a new set of institutions and even providers would be needed, and new products involving long term care and medical savings accounts would require greater monitoring of insurer solvencies and investment patterns to protect policyholders' interests.

The aim of regulation of health insurance should be to ensure increased healthcare access through managed competition. Everyone should have access to a basic package of health services at a set price, but anything beyond this would be the financial responsibility of individuals.

Regulation should:

- Focus public spending on primary care and public health activities
- Reform the Employee State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) including withdrawing it from those who can pay for healthcare
- Implement strict licensing and rating/credentialling of private healthcare providers along with formalisation and monitoring of the fees structures
- Review and revise the existing indemnity-based insurance schemes like Mediclaim
- Create mechanism and infrastructure for collection of information and data on diseases and related expenditures including their source

The Union Government has to :

- Develop a health policy
- Develop health personnel
- Allocate capital expenditure
- Guide development of the public and private sectors

The regulator should:

See to market standards (including consumer protection) and overseeing solvency and financial regulation.

The general picture that emerges is that legislation (existing and proposed) concerning health insurance in India is fairly comprehensive even in comparison to a model set of regulations when focusing on auditing, financial controls, investment guidelines and licensing regulations.

There is much less regulatory focus, however, on the consumer of insurance products and on overall goals of health policy in the form of regulation that curbs risk selection, protects consumers, promotes HMOs and the like.

Both the Insurance Act of 1938 and the IRDA Act are sufficiently comprehensive to allow increased focus on these issues, yet certain issues would need to be addressed.

The Healthcare Continuum

Aloke Gupta

"Among the different forms of intervention that can contribute to the provision of social security, the role of health care deserves forceful emphasis. Illness is, obviously enough, one of the most widespread causes of human deprivation and economic insecurity in India. It affects not only the actual patients and those who depend on them for their subsistence, but also other members of the society, in so far as the threat of disease arising from widespread morbidity reduces the quality of life... This is one field where there is an overwhelming need for bold initiatives and comprehensive reform"

Jean Dreze & Amartya Sen

Current healthcare expenditure in India is Rs.1,03,000 crores, which includes Rs.86,000 crores spent on healthcare delivery and Rs. 17,000 crores on pharmaceuticals (retail), representing 5.2 per cent of the GDP. This is comparable to the expenditure most developing countries incur on health.

However, the similarity ends here, since 64 per cent of the Rs. 86,000 crores is direct household spending on healthcare, perhaps one of the highest in the developing world. This signifies the fact that the burden of healthcare is disproportionately being borne by the individuals and households. The spending also shows a marked skew in favour of the urban population, that constitutes 25.7 per cent (1991) of the population.

The coverage of the population under private, social and other types of health insurance is limited to the extent of 15 per cent or probably less.

Private health insurance in the form of the Medilaim policy of the public sector unit (PSU) general insurance companies covers 77.80 lakh lives (2001-02), the Employees State Insurance Scheme (ESIS) covers 3.4 crore beneficiaries, the Central Government Health Scheme (CGHS) covers 40 lakhs and the Railways Health Scheme, 12 lakhs.

Other organised sector workers covered are: mining employees - 20 lakhs, defence employees including central police organisations - 70 lakhs (including families), ex-servicemen including families - 75 lakhs, plantation employees - 20 lakhs and so on. It is estimated that the population covered under various schemes operated by NGOs is around 5 per cent of the population – a figure that requires authentication.

The private health insurance market in India consists almost entirely of a single policy i.e., Medilaim, sold by the PSU general insurance companies and its clones being sold by the new private

insurance entrants. Medilaim, which was introduced in 1987, has undergone numerous changes, the most fundamental being the one in 1999 when internal sub-limits were removed, making it a single benefit limit policy.

The policy has since seen a steadily rising claims ratio. This change has created structural imbalance in choice and price parameters, and restricted the scope of creation of a new range of health insurance products.

There is a directly proportional relationship between choice and price. Greater choice commands higher price and vice versa.

This principle also applies to the product line in the healthcare continuum. A pre-insurance arrangement for meeting healthcare expenses is the Fee for Service system where the patient pays for every healthcare service that he consumes. The system offers free choice.

Health Insurance Jargon!

1. Accreditation – The process by which an authorised agency or organisation evaluates and recognises an institution or an individual according to a set of "standards" describing the structures and processes that contribute to desirable patient outcomes.

2. Coinsurance/Copayment – Portion of incurred medical expenses, usually a fixed percentage, that the patient must pay out of pocket.

3. Cost Containment – The control of the overall cost of healthcare services within the healthcare delivery system.

4. Coverage – A major classification of benefits provided by a health insurance policy, or the amount of insurance or benefit stated in the policy for which an insured is eligible.

5. Deductible – The amount of covered expenses that must be incurred by the insured before benefits become payable by the insurer.

6. Diagnosis-Related Group (DRG) – A system of categorising inpatient medical services and assigning specific reimbursement fees to each category.

7. Exclusions – Specified coverages, hazards, services, conditions, and the like that are not provided for (covered) under a particular health insurance contract.

8. Fee-For-Service – Method of charging whereby a physician or other practitioner bills for each visit or service rendered.

9. Group Policy – A contract of health insurance made with an employer or other entity (policyholder) that covers a group of persons identified as individuals by reference to their relationship to the contracting policyholder.

10. Health Insurance – Types of coverage providing for the payment of benefits as a result of sickness or injury including insurance for losses from accident, disability, medical expense, or accidental death and dismemberment.

11. HMO – Health Maintenance Organisation – An organisation that provides for a wide range of comprehensive healthcare services for a specified group at a fixed periodic prepayment.

12. Home Care – Medical and paramedical services delivered to patients at home. Included are obstetric services at home, home dialysis, telematic services, etc.; excluded are the consumption of medical goods (pharmaceuticals, other medical goods) dispensed to outpatients as part of private household consumption.

13. Indemnity – Health Insurance plan providing benefits in a predetermined amount for covered services. Traditionally, payment is made on a fee-for-service basis with no involvement by the insurer in the actual delivery of healthcare services.

14. Long Term Care – A wide range of health and personal care, ranging from simple assisted living arrangements to intensive nursing home care, for elderly or disabled.

In the healthcare continuum, the next stage is that of Indemnity Policies, that are akin to Fee for Service system except for the introduction of the element of pre-payment. The pre-payment mechanism though does not limit choice of healthcare providers, but the policy conditions do restrict the openness of a Fee for Service system.

The next stage in the continuum is the Managed Indemnity system where, apart from policy restrictions imposed through policy conditions, the choice of healthcare providers gets restricted to the provider network created by the insurer/third party administrator. The policy however, does not prevent the policyholder from seeking service from an out of network provider, except that the policyholder opts to forego the facility of 'cashless treatment' for that particular episode, which remaining within a network offers.

As we slide down the healthcare continuum, we enter the realm of managed care where at the end of the continuum, (Closed Panel or Staff Model) Health Maintenance Organisation) the choice gets restricted to either a closed ended network or even a single healthcare facility. However, this restricted choice of providers comes with a lower price, thus

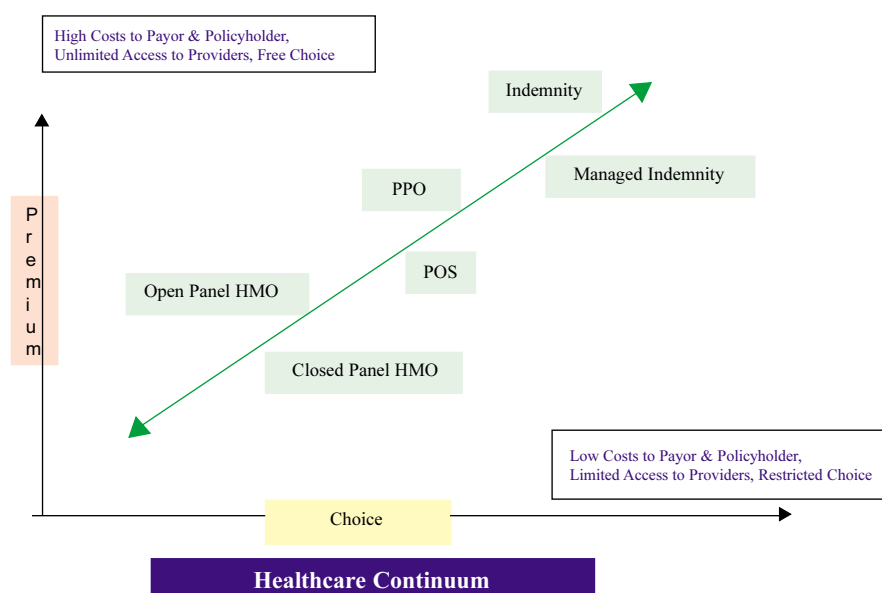
confirming to the principle – greater choice commands higher price and lower price limits choice.

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The author is a health insurance consultant.



15. Loss Ratio – The ratio of paid claims to earned premiums.

16. Managed Health Care – Healthcare delivery arrangements that are designed to control healthcare costs and improve utilisation of services.

17. Managed Indemnity – Use of provider networks, utilisation controls in traditional Indemnity health insurance plans in order to reduce costs and inappropriate care.

18. Medical Loss Ratio – The ratio between the cost to deliver medical care and the amount of money (premium) that was taken in by a plan/insurer. Insurance companies often have a medical loss ratio of 92% or more; tightly managed HMOs may have a medical loss ratio of 75% to 85%, although the overhead (or administrative cost ratio) is comintantly higher.

19. Medical Management – A system of patient or client assessment, planning,

treatment, referral, and follow-up to ensure provision of co-ordinated medical services.

20. Mediclaim – Hospitalisation policy being offered by the four public sector general insurance companies.

21. Negotiated Fees/Rates – Managed care plans and providers mutually agree on a set fee for each service. This negotiated rate is usually based on services defined by the CPT codes, generally at a discount from what the provider would usually charge.

22. Point of Service Plans (POS) – Combination of HMO and PPO features. They provide a comprehensive set of health benefits and offer a full range of health services much thew same as HMO. However, the members do not have to choose how to receive services until they need them. The member can then opt to use the defined managed care programme, or can go out-of-plan for services but pay the difference for

nonplan benefits (e.g. 100 percent coverage for managed care vs. 80 percent coverage out-of-plan)

23. Preferred Provider Organisation (PPO) – An arrangement whereby a third-party payer contracts with a group of healthcare providers to furnish services at lower-than-usual fees in return for prompt payment and a certain volume of patients.

24. Provider Network – A group of healthcare providers under contract with an insurance company or a third party administrator within a specific geographic area.

25. Third Party Administration – That method by which an outside person or firm, not a party to a contract, maintains all records regarding the persons covered under the individual/group insurance plan and may also pay claims using the draft book system.

Past & Present of Health Insurance

R. C. Sharma



The history of health insurance goes back to 1883 when, in Germany, an attempt was made to introduce a health insurance scheme for the

working classes. Subsequently the idea engulfed many European countries and with the passage of time entered North American and South American countries as well.

In India, the concept of insurance came from United Kingdom with the establishment of Oriental Life Insurance Company in 1818 in Calcutta in the life insurance segment and Triton insurance company in 1850 in Calcutta in the general insurance segment.

The idea of health insurance is catching up slowly but steadily in India. The old thinking that providing a healthcare system is the duty only of the state is waning and people have started looking to alternate sources of healthcare in terms of availability, quality, care and service.

This is primarily because of growing affluence in the urban areas. There is also an increasing awareness among the masses more because of the absence of quality healthcare services by the state, which can be attributed to many constraints.

Only a small section of the population has been covered under different health schemes of the Government. There is an imperative need for creating a larger awareness of the importance of health insurance amongst the people, particularly in those segments of the society which have been deprived of the quality health services in spite of their potential to pay for them and those areas where such services have remained inaccessible due to various reasons.

The first such initiative was taken during 1986-87 when the Mediclaim policy was introduced by the general

insurance companies. Though useful, it has many encumbrances and inconsistencies like that of exclusions, limitations and deductibles. All these factors combined with adverse selection and malpractices lead to high claims ratios.

Mediclaim policies since have been improved/modified.

With the opening up of the insurance sector, the expectations of entry of health insurers and their introduction of more attractive/viable health insurance policies have gained momentum. The experience of new general insurance companies, hitherto, has not been very encouraging in this field.

As on today no insurance company has come forward to function as a standalone health insurance company.

In the given scenario, the role of Insurance Regulatory and Development Authority (IRDA) is not only vital, it is also pivotal. The regulatory role of the Authority assumes more significance as concomitantly it has to perform as a developer of insurance industry also.

The introduction of Third Party Administrators (Health Services) in the insurance industry through its notification on IRDA (TPA-Health Services) Regulations, 2001, is a step towards that.

The idea of a TPA was conceived in the US primarily to help in cost containment and provide quality medical care. As of now many countries have tried this concept with varied experiences. The basic role of TPA is to function as intermediary between the insurer and the insured by providing administrative functions. In India, TPAs have been debarred from procuring / soliciting business.

TPAs-Health Services can help in the areas of curtailment of unnecessary treatment, to control costs, restriction to choice of appropriate care, pre-payment schemes help in improving the services etc and all these are expected to lead to lower premiums.

Some of the salient features of the TPA-Health Services Regulations are:

- At least one of the directors of the TPA shall be a qualified medical doctor registered with the Medical Council of India (MCI).
- The CAO/CEO of the TPA shall possess the educational qualifications mentioned in the regulations and also undergo a specified period of training with any institution recognised by the Authority.

As on date IRDA has licensed 22 TPAs.

The TPA-Health Services Regulations is a platform for the insurer and the provider to develop a relation to upgrade and improve the delivery of services. Through the emerging role of TPAs, insurance companies can lay more emphasis on consumer protection, can control risk selection and ensure availability of prescribed benefits.

TPAs are expected, besides helping in designing new products, to play an important role in controlling claims costs by implementing cost containment measures like pre-authorisation and utilisation management. TPAs can specify in contracts the kind of healthcare that is to be provided and can therefore concentrate on providing cost effectiveness. Consumers can see a definite link between their payments and services. Networking amongst the service providers can help get the best quality service without loss of precious time.

It is too early for the TPAs in health services to have an impact on the insurance industry in India.

They have to stabilise themselves in the given conditions. Once they overcome the initial hurdles the future path will be smoother.

Juxtaposed with the IRDA Protection of Policyholders' Interests Regulations-2002, it paves way for the consumers to avail the benefits of health insurance policies without any apprehension and reservations.

The author is Assistant Director, IRDA.

प्रकाशक का संदेश



दिसंबर के प्रारंभ में प्रकाशित आईआरडीए जर्नल के प्रथम अंक से यह निष्कर्ष निकाला जा सकता है कि ज्यादा सूचना स्वागत योग्य है। प्रकाशन के माध्यम से सूचना का प्रचार तथा आदान - प्रदान, बीमा के विभिन्न घटकों तक स्पष्ट रूप से स्वागत योग्य कदम है। जिस प्रकार आप सबने हमारे प्रयास तथा उत्साह के संबंध में समाचार प्राप्त किये तथा हमसे संप्रेषण किया वह प्रशंसनीय है। भारत तथा विदेश से व्यक्तिगत तथा लिखित अनुरोध पत्रिका की प्रति प्राप्त करने के लिये हमारे कार्यालय को प्राप्त हो रहे हैं जो भाव विभोर करने वाला है।

यह जर्नल प्राधिकरण का पहला उद्घरण है जो उद्योग तथा पहुँच कर उपभोक्ता जागरूकता का प्रचार कर रहा है। हम इस कार्य के लिये प्रसार भारती की सेवाएँ रेडियो तथा टेलीविजन के रूप में लेकर बीमा तथा पेंशन का प्रचार करना चाहते हैं। जल्द ही ऑल इंडिया रेडियो, दूरदर्शन के प्राइम टाइम पर धारावाहिक, लघु फिल्मों तथा अन्य कार्यक्रम देखने को मिलेंगे जिनमें वित्तीय संरक्षण के इन तरीकों के महत्व पर प्रकाश डाला जायेगा।

सूचना के साथ संप्रेषण भी महत्व रखता है तथा यह संदेश मैंने बार - बार दोहराया है।

इस माह से हम जर्नल की प्रस्तुति के लिये नये ढंग को प्रारंभ कर रहे हैं। प्रत्येक अंक बीमा उद्योग से संबंधित किसी महत्वपूर्ण मुद्दे को लेकर वाद - विवाद और परिचर्चा से प्रारंभ होगा अथवा एक ऐसी समस्या को लेकर जो हमें नितांत रूप से सामने आई है तथा उससे संबंधित कुछ तथ्य।

इसके बाद हम आपसे चाहेंगे की आप इसमें भाग लें और हम यहाँ आपको सुनने के लिये तैयार हैं।

पहली विषय वस्तु जो हम परिचर्चा के लिये आपके सामने रखना चाहते हैं वह है स्वास्थ्य बीमा तथा यह मुद्दा इस अंक का केन्द्र है।

भारतीय जनता के पक्ष की तरफ से मैं यह मुद्दा बहुत चिंता का मानता हूँ। मध्यम वर्ग तथा उससे नीचे रहने वाले लोग बुरा स्वास्थ्य झेल रहे हैं। गुणवत्ता के संबंध में तथा समर्थानुसार उनके पास अच्छे विकल्प उपलब्ध नहीं हैं। केवल अपनी बचत को खर्च करने के अलावा उनके पास बीमारी खर्च के वित्तीय पोषण के लिये कोई मार्ग नहीं है। यह भी सत्य है कि वे अपने दैनिक जीवन में बीमा के महत्व से अनभिज्ञ हैं। वह यह भी नहीं जानते की उनके भविष्य के लिये यह कितनी सुरक्षा प्रदान कर सकता है। यह सब हम प्राधिकरण द्वारा रेडियो व टेलीविजन के माध्यम से बदलना चाहते हैं।

यह स्पष्ट है कि स्वास्थ्य बीमा बाजार पर पकड़ बनाने के लिये पिछले वर्षों में कोई बड़े प्रयास नहीं हुये हैं। जो हमने सोचा था कि नये व पुराने व्यवसायी आपस में प्रतिस्पर्धा करेंगे तथा उत्पादों तथा सेवाओं की लंबी सूची उपलब्ध करवायेंगे जिसके लिये ग्राहक बेसबरी से इंजतार कर रहे हैं।

इसलिये प्रश्न है - सभी स्वास्थ्य बीमा के बड़े संभावित बाजार की बात करते हैं, लेकिन क्या कारण है कि भारतीय बाजार में कोई भी उत्पाद अब तक अच्छी शक्ल नहीं ले पाया है। बाजार क्या चाहता है? कौन सी रूकावटों को दूर करना है और यह सब कैसे करना है? यह सब बाजार को कैसे दिया जा सकता है? जो वह चाहता है तथा जिसकी उसे आवश्यकता है। कुछ बड़े - छोटे अन्य प्रश्न भी हैं। मेरे प्यारे उद्योग के सदस्यों, मैं चाहता हूँ कि सभी वर्गों द्वारा अधिकतम भागीदारी तथा परिचर्चा की जाये।

सभी प्रकार के प्रश्न तथा उत्तर उठाये जाये जिससे हम सभी संपूर्ण रूप से परिस्थितियों के सभी पक्षों को देख सके तथा रास्ता निकले जो हमें समाधान की तरफ ले जाये। सदा मुक्त, निष्कपट तथा उचित भाव से अपने लेखों द्वारा उद्योग में एक सर्वसम्मति बनाने के लिये आगे आये जो इसकी शक्ति बन सकेगी।

यह आई आर डी ए जर्नल का सेवा मर्म है। यदि हम शैक्षिक अथवा शोध संस्थान होते हम कुछ शोध पत्र तथा तकनीकी पत्रों को सामने रखते।

आई आर डी ए का दायित्व नियमित रूप से उद्योग की नरमी और गरमी की तरफ है। यह रास्ते का आसान बनाता है तथा उद्योग तथा समाज की नब्ज देखकर भविष्य के लिये रास्ता बनाता है। यह पीछे जाकर उद्योग को उसकी संपूर्णता में देखता है तथा उसका मूल्यांकन करता है जिससे सभी मजबूत बन सकें।

इसका यह प्रकाशन विनियामक तथा बीमा के बीच भ्रातृत्व का भाव पैदा करने के लिये है। मेरे द्वारा तथा मेरी कर्मठ टीम द्वारा यही भूमिका निभाई गयी है। जिसके द्वारा द्रुत तथा सरलता द्वारा सूचना तथा धारणा का प्रवाह दोनों तरफ हो सके।

सबसे महत्वपूर्ण यही है कि यह दोनों दिशाओं में संभव हो।

यह सही मायने में ठीक समय है, जब हम चर्चा करें दोनों दिशाओं की अब हम नये वर्ष के एक किनारे पर हैं और यह एक समय है जब हम पीछे तथा आगे देख सकते हैं। आये हम सभी यह सब साथ साथ करें।

नये वर्ष की शुभकामनाएँ।

एन. रंगाचारी

एन. रंगाचारी

८८ कुछ तो लोग कहेंगे ९९

मैं ग्राहकों में एक संतुष्टि का भाव देखता हूँ कि उन्हें प्रतिस्पर्धात्मक विकल्प उपलब्ध है। इस सांत्वना का भाव विस्तृत है लेकिन मुझे खेद है कि बाजार इस नव परिवर्तन तथा प्रतिक्रिया की आवश्यकता की पूर्ति नहीं कर पाया है। उद्योग को यह देखना है कि वह कैसे इन अपूर्ण इच्छाओं को पूरा कर सकता है।

एन. रंगाचारी, अध्यक्ष, आईआरडीए

सभी एजेंटों को हर प्रकार का प्रशिक्षण देना अप्रसांगिक है। कंपनियों को व्यापार के वितरण के लिये आला लोगों की जरूरत होगी। हमें अधिक गहन तथा कम सघन प्रशिक्षण की आवश्यकता है।

वी कृष्णन, उपाध्यक्ष राष्ट्रीय शाखा तथा एजेंसी ऑपरेशन टाटा ए आई जी जनरल इंश्योरेंस कंपनी

एक बहुत बड़ा संभावित बाजार राइटिंग निदेशक तथा आफिसर रिस्क के लिये है। बीमाकर्तव्यों ने इस ओर सोचना प्रारंभ भी नहीं किया है। उन्हें कंपनी की आंतरिक सक्रियता को समझना होगा। उन्हें योग्यता प्राप्त करने की जरूरत है कि जोखिम के मूल्य का निर्धारण कैसे किया जाये।

ओमकार गोस्वामी, चीफ इक्नोमिस्ट, सी आई आई

आईआरडीए ने साख बनायी है। मेरे पास विदेशी आते हैं तथा कहते हैं हमारी यह इच्छा है कि आपके जैसा विनियामक हमारे देश में भी होता। हमारे बीमा विनियामक विश्वस्तर के हैं, श्रीमान यह उद्योग निपूर्ण नहीं है। आप उन्हें यह कहते रहते हैं। आईआरडीए भी परिपूर्ण नहीं है। आप सदा सुनते रहते हैं।

तरुण दास, महा निदेशक, सी आई आई

उन्नति तथा भेदन क्षमता के लिये टैरिफ एक रूकावट है। प्रतिबंधित मूल्य मध्यस्थों के कार्य को नव परिवर्तन की बसावट को प्रभावित करेंगे। उद्योग उत्पादों को आगे ला रहा है। समाधानों को नहीं।

फली एस पोंचा, अध्यक्ष, अन्तर्राष्ट्रीय पुर्नबीमा तथा बीमा सलाहकार सेवा

यदि कोई भी पेंशन सुधारों का विरोध नहीं कर रहा है तो आपको चिंतित होना चाहिये।

मनीश सबरवाल, निदेशक, इंडिया लाइफ हैविट

वक्ताओं के
विचार

कंफडरेशन ऑफ इंडियन इंडस्ट्रीज(सी आई आई) द्वारा नवम्बर माह में हैदराबाद में आयोजित सातवें बीमा शिखर सम्मेलन में

क

बिरा खडा बाजार में सबकी माँगे खैर
ना काहू से दोस्ती ना काहू से बैर
ना काहू से बैर ज्ञान की अलख जगावे
भूला भटका जो होय राह ताही बतलावे
बीच सडक के मांहि झूठ को फोडे भंडा
बिन पैसा बिन दाम ज्ञान का मारे डंडा

गर्दिश में तारे

के. नित्य कल्याणी

जो 86,000 करोड़ से अधिक का है तथा 8000 करोड़ प्रति वर्ष प्रगति कर सकता है - यह है हेल्थकेयर तथा हेल्थ वित्तीय उद्योग जिसकी गणना विभिन्न परामर्शदाताओं तथा शोधकर्ताओं ने कुछ वर्ष पहले की थी लेकिन कोई भी इस अवसर का लाभ उठाने के लिये अब तक प्रोत्साहित नहीं हुआ है।

यह सब ऐसे समय में नहीं हो पा रहा है जब उद्योग में मंदी आने की संभावना हो ही नहीं सकती। हम सभी कभी न कभी बीमार पड़ते हैं तथा बार बार बीमार पड़ते हैं। हम डॉक्टर के पास जाते हैं तथा अपने बच्चों को डॉक्टर के पास ले जाते हैं। यह आवश्यकता सर्वव्यापक है तथा यह सर्वव्यापकता भारत जैसे देश में अधिक ही है।

फिर भी हेल्थ केयर वित्तीय सपने का क्या हुआ? यह आगे क्यों नहीं बढ़ पा रहा है? क्यों हेल्थ बीमा का एक मृगतृष्णा बना हुआ है।

बहुत साल पहले की बात है, सालों को अब गिनने से कोई फायदा नहीं मैंने न्यू एंशुरेंस कंपनी में बिना सूत्र के नये रंगरूट के रूप में कार्य भार संभाला। सार्वजनिक क्षेत्र की उबाऊ कार्य प्रणाली मेरे सामने थी।

लेकिन हवा में कुछ उत्तेजना भी थी। एक नयी पॉलिसी जारी होने वाली थी तथा सभी स्टाफ सदस्य एक ग्रुप में हमारे कार्यालय में खड़े थे तथा इसके बारे में बात कर रहे थे तथा प्रधान कार्यालय से दस्तावेज मिलने का इंतजार कर रहे थे।

न्यू इंडिया तथा अन्य बीमा कंपनियाँ मेडीक्लेम पॉलिसी प्रारंभ करने वाले थे। यह एक मेडिकल पॉलिसी थी। उस साल की वह पहली व्यक्तिगत आधार पर अस्पतालीकरण पॉलिसी थी जिसका मूल्य भी इस आधार पर किया गया था तथा इस उत्पाद की एक ब्रांड पहचान भी थी। यह जंग लग चुकी अग्नि पॉलिसी है तथा मैरिन फ्लोटिंग पॉलिसी से अलग प्रचंड रूप से सामने आयी।

इससे ज्यादा क्या, यह पॉलिसी जल्दी में तैयार की गयी जिसका करण तत्कालीन प्रधानमंत्री राजीव गाँधी द्वारा संसद में मेडिकल बीमा जारी करने की घोषणा करना था।

पहली बार बीमा उद्योग को यह सब सुनने को मिला तथा प्रीमियम पर कर रियायत के कारण लोगों को यह बीमा खरीदने के लिये प्रोत्साहन मिला।

बहुत से लोगों को ऐसा लग रहा था शायद वह ही सब कुछ था। ऐसा ही प्रधानमंत्री का आकांक्षायें जिनमें हेल्थ को तकनीकी मिशन के रूप में लिया गया लेकिन ऐसे वैधानिक उत्पादों का एक अद्भुत तथा सजीव चक्र होता है जो मेडीक्लेम के लिये भी साबित हुआ।

और यह सब कुछ न्यू इंडिया के एक रंगरूट के सामने हुआ।

उत्पाद अपनी सारणी तथा दरों के साथ सामने आया। ग्राहकों ने इसको कुछ हद तक अपनाया भी प्रारंभ किया। विशेष रूप से वित्तीय वर्ष के अंत में कर लाभ उठाने के लिये।

उत्पाद के साथ कुछ आधारभूत समस्याएँ भी थी जिसमें आवरण तथा शर्तों में लचीलेपन की कमी प्रमुख थी। बाजार में अन्य उत्पाद न होने के कारण यह उत्पाद कुछ हद तक प्रचलित हुआ। व्यक्तिगत पॉलिसी दर प्रीमियम बहुत ही कम था। इसी कारण बिक्री कमीशन भी बहुत कम रहा। ऐसे संसार में जहाँ एजेंट जो कुछ बेचना चाहता है वही बेचता है। कम कमीशन के कारण एजेंटों द्वारा इस पॉलिसी की तरफ विशेष ध्यान नहीं दिया गया। इससे अधिक महत्वपूर्ण था यदि आप स्वयं अच्छे सैल्समैन हैं तो आपको एक एजेंट मिल जायेगा जो आपको मेडीक्लेम पॉलिसी बेचने को तैयार होगा।

ग्राहकों की असंतुष्टी तेजी से बढ़ी तभी यह अंदाजा लगा की वास्तव में यह मेडीक्लेम पॉलिसी

नहीं है - इसमें केवल अस्पताल में दाखिल होने के बाद के खर्चे दिये जाते हैं। आम सर्दी खाँसी के नहीं वह भी विशेष शर्तों के अनुसार। अपवर्जन, पहले से बीमारी तथा दावे अस्वीकृत होने के परिणामस्वरूप समाचर पत्र के संपादकों के गुस्से भरे पत्र मिलने लगे तथा उपभोक्ता अदालतों में मुकद्दमें प्रारंभ हो गये। जिसके कारण इस उत्पाद के बारे में उद्योग ने बात करना भी बंद कर दिया।

जल्द ही मेडीक्लेम पॉलिसी बड़े निगमित ग्राहकों को एक तोहफे के रूप में ग्रुप मेडीक्लेम के रूप में जारी की जाने लगी। जब ऐसे ग्राहक अन्य बड़ा बीमा व्यापार देते थे तो उन्हें इसके लिये कैसे ना कहा जा सकता था।

अन्य मेडीक्लेम कर राहत के कारण बेची जाती थी और धीरे धीरे यही बड़ा सिरदर्द बन गया।

इसको बड़ा धक्का लगा जब बड़े घपले तथा घोटालों के द्वारा मरीज, डॉक्टर यहाँ तक की कुछ बड़े अस्पताल इस पॉलिसी का अनुचित लाभ उठाने लगे।

उन्होंने अपनी पहले से होने वाली बीमारी को छुपाया, ज्यादा फीस ली, ज्यादा और बिना बात के जाँच पड़ताल करवायी, बिना बात अस्पताल में भर्ती करवाया गया - यहाँ तक की बाद में मेडीक्लेम को सर्जरी के लिये भी दुरुपयोग किया गया। इतने बड़े पैमाने पर यहाँ तक की बड़े बड़े अस्पतालों द्वारा किये गये घपलों और घोटालों के कारण उद्योग ही चरमरा गया। न्यू इंडिया द्वारा अपने बड़े ग्राहकों की महत्वपूर्ण मेडीक्लेम पॉलिसी को नवीकरण शुल्क लगाने के कारण यूनाइटेड इंडिया की तरफ मोड़ देने पर रहात की साँस ली गयी।

यह भी एक कहानी है कि यूनाइटेड इंडिया ने यही पार्सल अगली कंपनी को भेज दिया तथा यह कार्य चारों बीमा कंपनियों के बीच चलता रहा।

यह समस्याएँ इस लिये आयी की हेल्थ क्षेत्र में संगठन की कमी रही तथा वह किसी भी तरह समाहित करता रहा। यह समस्या आज विकराल

रूप से ज्यादा डॉक्टरों तथा अस्पतालों तक पहुँच चुकी है।

बीमा उद्योग को उपचार की अधिक जानकारी नहीं है। बीमा उद्योग ने कोई भी मानक दरे' उपचार के लिये तय नहीं की है। बीमा उद्योग के पास डॉक्टर नहीं है। वह नये लोगों की भर्ती तो करता है (जानवरों के डॉक्टर ग्रामीण क्षेत्र के लिये...) साथ ही पूरे देश में कोई प्रासांगिक मेडीकल इतिहास लिखने की व्यवस्था नहीं है। ऐसी कोई व्यवस्था नहीं है कि जिसके अनुसार यह बताया जा सके की व्यक्ति को कब बीमारी हुई थी, यदि मुझे हार्ट अटैक हुआ था तो वह तब तक मालूम नहीं हो सकेगा जब तक मैं न बताऊँ और यह हेल्थ बीमा लेखन के लिये एक खिलौना सा बन कर रह गया है।

दावा अनुपात ने आसमान को छू लिया लेकिन अभी भी इस व्यापार को लाभ के व्यापार में बदलना संभव है। लेकिन बढ़ा हुआ प्रीमियम तथा प्रासांगिक आवरण वेल्यु एडेड लाभों के साथ एक बार में केन्द्रीय प्रत्यक्ष कर बोर्ड द्वारा यह कह कर दबा दिया गया की मेडीक्लेम प्रीमियम पर कर रियायत मात्र 15000 रुपये प्रीमियम तक ही होगी जो मूल पॉलिसी का प्रीमियम था। जबकि पॉलिसी प्रारंभ की गयी थी। इसलिये उद्योग इस उत्पाद को बेहतर बनाने में असमर्थ रहा तथा ग्राहकों को विस्तृत आवरण न दिया जा सका उसी दरों पर भी।

उद्योग हमेशा इस उत्पाद को लेकर डरता रहा तथा बाजार की कमी हेल्थ के कारण बीमा उपलब्ध नहीं हो सका। जिसकी उसे कामना थी

तथा भारतीय उद्योग की एक त्रासदी यह भी रही की मेडीक्लेम हेल्थ बीमा का पर्याय बन गया।

सामाजिक व आर्थिक रूप से इस समस्या को लंबे समय तक अनदेखा नहीं किया जा सकता। हेल्थ बीमा में व्यापारिक अवसर के रूप में असली हेल्थ बीमा को प्रकट होना ही होगा और वह भी जल्दी ही।

हम आगे के पृष्ठों में हेल्थ बीमा से संबंधित विषयों को तथा भारत में स्वास्थ्य क्षेत्र तथा नयी दो रिपोर्ट के सारांश पर चर्चा करेंगे जिनमें इस क्षेत्र पर सुझाव दिये गये हैं। यह आई आर डी ए का प्रथम कदम है जो उद्योग में बड़े पैमाने पर इस विषय पर विवाद के लिये मंच प्रदान कर रहा है और यह आगे वाले अगले अंकों में भी जारी रहेगा ...

लोक शिकायत

आईआरडीए ने अपने कार्यालय में एक प्रकोष्ठ स्थापित किया है जो बीमाधारकों से प्राप्त शिकायतों, प्रतिवेदनों आदि को प्राप्त करता है तथा उन पर अनुवर्ती कार्यवाही करता है।

देश के 12 नगरों में बीमा लोकपाल की स्थापना की गयी है तथा वह काफी अच्छी तरह से अपना कार्य कर रहे हैं फिर भी आम जनता से दावों के निपटान में देरी तथा ग्राहक की बात बीमा कंपनियों द्वारा ठीक प्रकार से न सुने जाने की शिकायतें प्राप्त होती हैं।

अतः प्राधिकरण ने एक लोक शिकायत प्रकोष्ठ की स्थापना की है जिससे ऐसी शिकायतों का निपटारा शीघ्रता से किया जा सके।

आईआरडीए कभी भी और कैसे भी बीमा लेखन का कार्य नहीं करना चाहता है तथा बीमा लेखन परिपाटियों, दावा प्रक्रिया को व्यक्तिगत बीमाकर्ताओं पर छोड़ देना चाहता है। यह केवल सामान्य जनता निष्कपट मामलों को लोक शिकायत के रूप में हल करना चाहता है।

लोक शिकायत प्रकोष्ठ का गठन इस प्रकार किया गया है :-

श्री प्रबोध चंदर - कार्यकारी निदेशक
श्री रणदीप सिंह जगपाल - उप निदेशक
श्री अनिल कुमार अरोडा - उप निदेशक
श्रीमती रश्मि जगदीप अभिचंदानी - सहायक निदेशक
आम जनता अपनी शिकायतें निम्नलिखित पते पर कर सकती है :-

बीमा विनियामक तथा विकास प्राधिकरण

5-9-58 बी, तृतीय तल, परिश्रम भवन, बशीरबाग,
हैदराबाद - 500 004

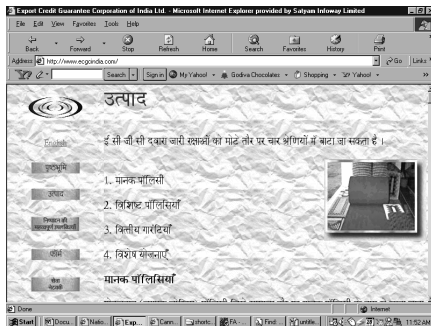
वेब पोर्टल

संजीव जैन

आईआरडीए की स्थापना के पीछे उनके उद्देश्यों में से सबसे महत्वपूर्ण उद्देश्य बीमा का प्रचार - प्रसार करना रहा होगा। भारत में प्रति व्यक्ति बीमा प्रीमियम की तुलना जब अन्य देशों से की जाती है तो जहाँ एक तरफ निराशा हाथ लगती है तो दूसरी तरफ इतने बड़े बीमा बाजार की उपलब्धता का अहसास भी होता है। बीमा को आम जनता तक पहुँचाने में बहुत सी बातों में जनता को समझ आने वाली भाषा में संपर्क स्थापित करना महत्वपूर्ण है।

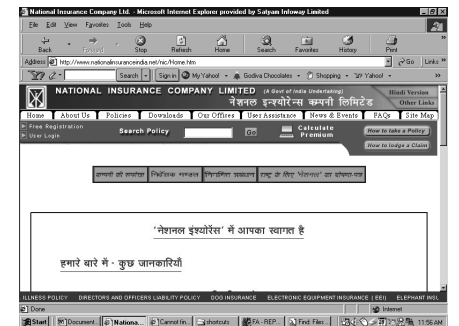
पिछले दशक में सारी दुनिया ने कंप्यूटर क्रांति को देखा है तथा कंप्यूटर के प्रायोजन को समझा भी है। भाषा के साथ बीमा प्रचार के लिये दूसरी महत्वपूर्ण बात तकनीक की आती है। आज ज्यादा से ज्यादा कंपनियाँ कंप्यूटर का प्रयोग अधिक से अधिक लोगों तक पहुँचाने के लिये कर रही हैं और इसी कंप्यूटर तकनीक की देन है वेब पोर्टल अथवा वेब साइट। दुनिया में सबसे तेज गति से विकास इसी तकनीक का हुआ है।

आज वेब पोर्टल के द्वारा ऐसे क्षेत्र में बीमाकर्ता पहुँच पा रहे हैं जहाँ पहले से बीमा के बारे में काफी जागरूकता है लेकिन नये क्षेत्रों में पहुँचने के लिये जरूरी है कि उस क्षेत्र की भाषा से संपर्क स्थापित किया जाये। आज वेब पोर्टल



को स्थानीय भाषा में विकसित कर जनता तक पहुँचने की बात शायद जल्दबाजी होगी।

सैद्धांतिक रूप से यह स्वीकार करने से पीछे नहीं रहा जा सकता की किसी भी बात को आगे बढ़ाने के लिये राष्ट्रभाषा महत्वपूर्ण स्थान रखती है। इस मानसिकता को ध्यान में रखते हुये जब हमने जानना चाहा कि कितने बीमाकर्ता ऐसे हैं जो इस बात को लेकर जागरूक हैं तो हमारे सामने तीन नाम आये। भारतीय जीवन बीमा निगम, नेशनल इन्श्योरेंस कंपनी लिमिटेड तथा ई सी जी सी, इन तीनों कंपनियों ने अपनी वेब साइट को हिन्दी भाषा में उपलब्ध करवाया है जिसके लिये निःसंदेह ये बधाई के पात्र हैं। उम्मीद की जा सकती है कि आने वाले वर्ष में और अधिक



बीमाकर्ता अपनी वेब साइट में हिन्दी भाषा का विकल्प उपलब्ध करवायेंगे।

लेखक
उप निदेशक, आईआरडीए।

देरी से दावा भुगतान पर जुर्माना

बीमा विनियामक और विकास प्राधिकरण ने बीमाधारकों के हितों से संबंधित विनियम 2002 के अनुसार कोई भी बीमा दावा किसी भी बीमा पॉलिसी के अंतर्गत सभी संबंधित दस्तावेजों के प्राप्त होने के 30 दिन के भीतर भुगतान कर दिया जाना चाहिये अथवा दावा भुगतान न किये जाने के कारणों का भी इसी अवधि के अंदर बीमा धारक को बता देना चाहिये।

यदि बीमाकर्ता दावा प्रक्रिया में देरी करता है तो उसे दावा राशि पर उस वर्ष के प्रारंभ में लागू बैंक ब्याज दर से 2 प्रतिशत अधिक ब्याज दावा राशि पर देना होगा।

प्राधिकरण द्वारा साधारण जनता से संपर्क करते समय यह तथ्य सामने आया है कि बीमाकर्ताओं विशेष रूप से सार्वजनिक क्षेत्र की बीमा कंपनियों ने इन प्रावधानों को लागू नहीं किया है।

परिचालन कार्यालयों में कहा जाता है कि उन्हें अपने रिपोर्टिंग कार्यालयों से अभी सूचना प्राप्त होनी बाकी है तथा उन्हें आईआरडीए से यह सूचना प्राप्त होनी है जिससे इन विनियमों के प्रावधानों को लागू किया जा सके।

आईआरडीए ने 10 दिसंबर को यह स्पष्ट कर दिया था कि दिनांक 26 अप्रैल 2002 को राजपत्र जारी होने के साथ ही यह विनियम लागू हो गये हैं।

स्पष्टीकरण दिया गया है कि पहले से ही प्राधिकरण को बीमाधारकों से सूचना प्राप्त हो रही है जिसमें दावों के भुगतान में बहुत देरी की शिकायतें कर रहे हैं। ये ऐसे दावे हैं जिन्हें स्वीकार तो कर लिया गया है तथा जिन पर बीमाकर्ता द्वारा कोई दावा निरस्तीकरण पत्र नहीं भेजा गया है।

प्राधिकरण यह स्पष्ट कर देना चाहता है कि ऐसे मामलों में बीमाधारक न केवल ऊपरी दावे की राशि का हकदार होगा साथ ही इस राशि के अतिरिक्त देरी से किये गये भुगतान के लिये ब्याज का हकदार भी होगा।

कैसे कैसे बीमा !

आम तौर पर बीमा क्षेत्र में लॉटरी, जुआ इत्यादि के लिये कोई स्थान नहीं है। लेकिन आश्चर्यजनक बात यह है कि लायड्स ने एक बीमा पॉलिसी जारी की जो अप्रत्यक्ष रूप से लॉटरी से जुड़ी है।

ब्रिटेन के नियोक्ता अपने आप को कर्मचारियों द्वारा लॉटरी जितने की स्थिति में कंपनी को होने वाले नुकसान के प्रति बीमा ले सकते हैं। 40 हजार से 76 लाख यू.एस. डॉलर की सुरक्षा प्रदान

करने वाली यह पॉलिसी कर्मचारियों द्वारा ब्रिटेन की राष्ट्रीय लॉटरी में 15 लाख यू.एस. डॉलर से अधिक जीतने के परिणाम स्वरूप यदि व्यक्ति 14 दिनों के अंदर नौकरी से त्याग पत्र दे देता है तो ऐसी अवस्था में नयी भर्ती तथा अन्य संबंधित खर्चों के लिये बीमा सुरक्षा प्रदान करता है।

अंग्रेजी में तैयार किये गये टी. वी. सीरियल हू वांट टू बी मिलिनियर (कौन बनेगा करोड़पति) के बड़े पुरस्कार के लिये भी लायड्स के कट्टी सार्क व्हिस्की ने एक पॉलिसी तैयार की जिसके अंतर्गत विजेता को दी जाने वाली 1.5 मिलियन डॉलर पुरस्कार को बीमा सुरक्षा प्रदान की गयी।



बदलता उद्योग जीवन बीमा उत्पाद

दिनेश चंद्र खनसीली



बीमा विनियामक और विकास प्राधिकरण (आईआरडीए) एक के अस्तित्व में आने के पश्चात, वर्ष 2000 में प्रथम जीवन बीमा कंपनी को लाइसेंस देने के

उपरान्त बाजार में नये - नये जीवन बीमा उत्पाद आने लगे। इस लेख का मुख्य उद्देश्य यह है कि जीवन बीमा के राष्ट्रीयकरण के बाद 1956 से लेकर 2000 तक, भारतीय जीवन बीमा निगम के उत्पादों में तथा 2000 के पश्चात लगभग दो वर्षों में निगम व निजी जीवन बीमा कंपनियों के इन उत्पादों में कोई अंतर भी आया अथवा केवल नयी बोलत में पुरानी शराब भरने जैसी कहावत ही सिद्ध हो रही है तथा साथ ही यह पाठकों के ऊपर छोड़ा गया है कि वे क्या निष्कर्ष निकालते हैं।

पहले पहल बाजार में नयी जीवन बीमा कंपनियों द्वारा जो जीवन बीमा उत्पाद (लाइफ इंश्योरेंस प्रोडक्ट्स) लाये गये वे परंपरागत उत्पादों जैसे ही थे। जैसे बंदोबस्ती बीमा (इंडोमेंट इंश्योरेंस), मनी बैक प्लान आदि। नयी कंपनियों को बाजार में पैठ बनाने के लिये ये उत्पाद ही बाजार में लाने पड़े। बाजार के सर्वे में भी यह उभरकर आया कि इन उत्पादों को बाजार में बेचने व समझाने के लिये ज्यादा प्रशिक्षण / शिक्षण की आवश्यकता नहीं होगी। अभिकर्त्ताओं (एजेंट) तथा जनता को भी इन उत्पादों की जानकारी थोड़े से श्रम द्वारा ही दी जा सकती है। यद्यपि ये परंपरागत (ट्रेडिशनल) उत्पाद ही थे परंतु कुछ कंपनियों ने इन्हें आकर्षक व नवीनतम रूप में पेश किया। जैसे सकल (सिंगल) प्रीमियम भुगतान विधि पॉलिसीधारकों को रास आई, जिसमें बार - बार प्रीमियम देने के झंझट से मुक्ति मिली। यद्यपि पहले भी यह विकल्प था, परंतु बाजार में इस बाबत ज्यादा जानकारी न थी। परिपक्वता (मैच्योरिटी) दावा, एक मुश्त देने के साथ साथ बीमाधारकों को अपनी इच्छानुसार अथवा क्रमबद्ध ढंग से नियत समय में लेने जैसा विकल्प मिला।

नयी कंपनियों ने एक बार परंपरागत उत्पादों के साथ बाजार में उतरने के बाद उन उत्पादों को बाजार में लाने का बीड़ा उठाया जिन्हें अब तक बाजार में किन्हीं कारण वश नहीं लाया जा सका था। जैसे लंबे समय की टर्म पॉलिसी, जहाँ केवल मृत्यु बीमा ही होता है और परिपक्वता लाभ कुछ नहीं होता। ऐसी पॉलिसी में प्रीमियम दर बहुत कम होती है। पहले बाजार में दो वर्षीय टेम्पररी टर्म पॉलिसी ही थी और इसे वे लोग ही खरीदते थे जो कम समय के लिये विदेश गमन करते थे। सामान्य जन तक इन पॉलिसियों की जानकारी नगण्य ही थी। प्रतियोगिता होने के कारण, भारतीय जीवन बीमा निगम भी लंबे समय की टर्म पॉलिसी को बाद में राइडर की तरह लाया।

इसके बाद दौर आया यूनिट लिंकड तथा यूनिटाइज्ड लाभ सहित पॉलिसियों का जहाँ डेथ कवर के साथ साथ बीमाधारक को बाजार के उतार - चढ़ाव में भागीदार होने का विकल्प मिलता है। पहले बाजार में बीमा प्लस के नाम से ऐसी एकमात्र पॉलिसी थी और सामान्य जन को इसकी समुचित शिक्षा भी सीमित मात्रा में थी। अभी भी इन पॉलिसियों की जानकारी जनता को तथा अभिकर्त्ताओं को समुचित मात्रा में दिये जाने की आवश्यकता है। जहाँ बीमाधारक को यह पता होना चाहिये कि वह जान बूझकर जोखिम ले रहा है। इस क्रम में वह अन्य पॉलिसियों के विपरीत उच्च लाभ के साथ साथ हानि भी उठा सकता है। कुछ कंपनियों ने इनमें गारंटी भी दी है।

बाजार में राइडर का नाम भी उभरकर आया। इसमें मूलभूत पॉलिसी (बेसिक पॉलिसी) के साथ अन्य लाभ वाली पॉलिसी भी एड ऑन राइडर की तरह जुड़ी रहती है। इसमें मूलभूत पॉलिसी की अपेक्षा कम खर्च होने के कारण प्रीमियम भी कम होता है। साथ ही बीमाधारक के पास विकल्प भी होता है कि वह राइडर ले अथवा न ले अथवा एक बार लेने के पश्चात भविष्य में इसे कालातीत (लैप्स) करवा ले। यदि राइडर कालातीत हो जाता है तथा मूलभूत पॉलिसी पहले की तरह ही अपने पूर्ण लाभों के साथ जारी रहती है। राइडर जैसे बंदोबस्ती बीमा के साथ सामान्य मृत्यु, दुर्घटना में मृत्यु एवं अंग भंग, दुर्घटना में मृत्यु केवल, मारक बीमारियों जैसे कैंसर, किडनी का प्रत्यारोपण, हॉस्पिटल बेनिफिट, हृदयघात आदि के कवर के रूप में दिया जा सकता है। यहाँ राइडर मूलभूत पॉलिसी में वर्तमान में एकमात्र एक्सक्लूजन्स आत्महत्या संबंधी है जिसमें यदि बीमाधारक पॉलिसी लेने के एक वर्ष के अंदर आत्महत्या करता है तो नामित व्यक्ति को बीमा धन नहीं मिलेगा। परंतु राइडर में आत्महत्या के अतिरिक्त पहले व बाद के वर्षों में अन्य एक्सक्लूजन्स हो सकते हैं। परंतु प्रायः राइडर का चयन पॉलिसी लेते समय ही करना पड़ता है। बाद में बीमाधारक द्वारा एंटी सलेक्शन (विपरीत चयन) के कारण यह संभव नहीं है।

इसके साथ ही बाजार में प्रतियोगिता भाव भी देखने को मिला। टर्म पॉलिसी में प्रीमियम दर कम करने की होड़ सी लगी। नतीजा हुआ बहुत कम प्रीमियम पर बहुत ज्यादा मृत्यु कवर। निःसंदेह प्रतियोगिता ग्राहक के लिये फायदेमंद साबित हुयी।

इसके साथ ही एकल प्रीमियम पॉलिसी, जहाँ कंपनियों ने गारंटी प्रदान की, जनता के बीच बहुत लोकप्रिय साबित हुई। बहुत सारी कंपनियों में इन पॉलिसियों में प्राप्त प्रीमियम कुल प्रीमियम आय का, अन्य पॉलिसियों के मुकाबले, अधिकांश हिस्सा रहा। ऐसी पॉलिसियों को लगातार मॉनिटरिंग की आवश्यकता होती

है। गिरती हुयी ब्याज दर के परिपेक्ष्य में इनमें लगातार पुनर्समीक्षा की आवश्यकता पड़ती रही। इसी वजह से भारतीय जीवन बीमा निगम को भी अपने बीमा निवेश पॉलिसी में भी परिवर्तन लाने पड़े।

इन दो वर्षों में गिरते हुये ब्याज दर के मद्देनजर, भारतीय जीवन बीमा निगम ने भी अपने उत्पादों में परिवर्तन किया। उसने अपनी पॉलिसियों जीवन श्री, जीवन धारा / जीवन सुरक्षा, बीमा किरण, जीवन अक्षय आदि में परिवर्तन किये।

आईआरडीए के ग्रामीण एवं सामाजिक बाध्यता अधिनियम 2000 के अंतर्गत प्रत्येक जीवन बीमा कंपनी को कुछ बीमा ग्रामीण क्षेत्रों व सामाजिक क्षेत्रों में करना जरूरी है। इनके लिये भी कंपनियाँ नवीनतम पॉलिसियाँ लायी। ये पॉलिसियाँ प्रायः इन्हीं क्षेत्रों तक सीमित रहेगी। इन बाध्यताओं को पूरा करने के लिये कंपनियों द्वारा समूह बीमा व व्यक्तिगत (इंडिविजुअल) पॉलिसियाँ, कम प्रीमियम के साथ यहाँ के लोगों की बीमा सुरक्षा हेतु लाई गयी।

उपरोक्त के साथ समूह क्षेत्र में भी बीमा कंपनियाँ समूह पॉलिसी (ग्रुप पॉलिसी) लायीं। जैसे ग्रुप टर्म इंश्योरेंस, ग्रुप ग्रेज्युटी सुपरएन्युशेशन पॉलिसी। यह पॉलिसियाँ विभिन्न राइडर के साथ भी लायी गयी तथा बीमित व्यक्ति को कई विकल्प भी दिये गये जैसे ग्रुप टर्म इंश्योरेंस में व्यक्ति विशेष द्वारा ग्रुप छोड़ने पर वैयक्तिक बीमा की पेशकश आदि। ग्रुप प्लान यूनिट लिंकड प्लान के साथ भी सामने आयी।

आज मनुष्य अपने एक्टिव जीवन के दौरान जिस तरह से जीवन यापन करना चाहता है, वह चाहता है कि एक्टिव जीवन के उपरांत भी उसका लाइफ स्टैंडर्ड वैसा ही रहे। इसमें वैयाक्तिक पेंशन स्कीम, एकुमुलेशन फेस के लिये डिफर्ड एन्युटी तथा भुगतान फेस के लिये इमिडियेट एन्युटी बाजार में लायी गयी। डिफर्ड एन्युटी भी बंदोबस्ती अथवा यूनिट लिंकड की तरह सामने आयी। इंकम टैक्स की धारा 80 सी सी सी के अंतर्गत यहाँ दिया गया 10000 रु. तक का प्रीमियम इंकम टैक्स से छूट के लिये पात्र होता है।

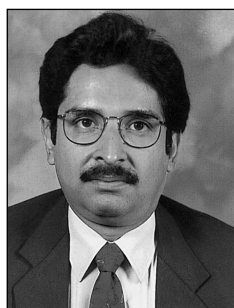
प्रतियोगिता का असर ग्राहकों के लिये इस रूप में भी फायदेमंद रहा कि बाजार में धूम्रपान करने वालों व धूम्रपान न करने वालों के लिये अलग - अलग प्रीमियम की अवधारणा सम्मुख आई। इस तरह धूम्रपान न करने वाले कम जोखिम (लो रिस्क) वाले माने गये व उनसे कम प्रीमियम चार्ज हुआ।

लेखक

उप निदेशक, आईआरडीए।

Rules for Referees

Arup Chatterjee



In the first part of this article the author tries to identify and monitor developments in global standards and codes in the area of insurance

with specific reference to those prescribed by the International Association of Insurance Supervisors (IAIS) and the twenty Insurance Guidelines issued by the OECD.

In the second part of this article, to be carried in the next issue, he will see how they apply to the Indian financial system and chalk out a road map for aligning India's standards and practices to international best practices.

Today insurance is the most important and fastest growing segment of the domestic financial sector in most developed and some emerging markets. This trend is marked by privatisation, increased use of contractual savings products, financial consolidation, and full or partial funding of pension systems. In the coming years in a number of the emerging market economies, rapid life insurance industry growth will be more as a result of the convergence of the life insurance and contractual savings sectors.

It is common knowledge that while in the early stages of economic development insurance expenditures relative to Gross domestic product (GDP) are low and, as per capita income in countries increases, the importance of insurance in the national economy tends to increase rapidly, reaching a saturation point at around the current stage of development of the insurance industry in developed countries. Therefore, one can expect the importance of the insurance sector in the global financial system to continue to increase.

A resilient, well-regulated insurance system contributes to financial stability and efficient resource allocation besides

playing a leading role in supporting economic and financial development as a provider of protection from financial losses. It is this fact that allows investors to enter into commitments that they might not have otherwise been prepared to consider.

Accordingly, the insurers' efforts at mitigating risk and making transfer of risk more affordable and manageable contribute to financial development. In addition, borrowers and issuers of equity have access to a pool of funds that insurance companies are willing to invest for the long term, thus contributing to the development of capital markets. Conversely, in some economies, the lack of catastrophe insurance can represent an economic vulnerability and impede development through the need to divert public resources after a disaster occurs.

The growing internationalisation of insurance and the need for enhanced cross-border supervisory co-ordination

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The underlying philosophy of modern insurance supervision is to identify problem companies early, act promptly, and apply effective intervention.

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are creating new challenges for the supervisory authorities and therefore call for better understanding of the implications for the financial system, with greater attention to systemic stability concerns relating to the insurance sector. The latter stem largely from ownership linkages between the banking and insurance sectors or because insurance sector distress has directly affected the availability of claims payments to key sectors in the real economy. In only a few such instances have the authorities used public funds to assist in the resolution of systemic problems.

Insurance supervisors began working together at the broad international level less than a decade ago and are primarily concerned with policyholder protection rather than systemic risk or development issues. This approach has strongly influenced the development of the internationally recognised regulatory principles. The underlying philosophy of modern insurance supervision is to identify problem companies early, act promptly, and apply effective intervention. This requires solvency margins which are large enough to provide the time needed to resolve problems so that policyholder benefits are protected.

While the insurance industry is changing in response to the demand for new products and services, the management and control of the insurers have not necessarily evolved as rapidly. As a result, there continues to be a wide range of practices in use for measuring and managing the risks in life and general insurance. In addition, there is continuing discussion between the industry and the supervisors about how the recent changes should translate into new practices and standards within the industry.

Reinsurance is a significant part of both life and general insurance. At best, reinsurance is only lightly regulated in most countries but represents one of the major assets on the balance sheets of many general insurers. The global general insurance industry remains heavily exposed to a small number of internationally active reinsurance companies who have traditionally maintained very conservative accounts. However, capital market pressures for more 'efficient' use of capital, including a growing demand for transparency may reduce capital ratios within these companies, which could have a negative effect on the overall security of the insurance sector.

The International Association of Insurance Supervisors (IAIS) was established in 1994 and became a standard-setting body in 1996. The

latest version of the (ICP) and the Insurance Core Principles (ICP) Assessment Methodology was adopted by the IAIS members in October 2000.

The ICP provides a framework of 17 supervisory principles that need to be in place for effective insurance supervision (See box for list.) The IAIS regards these as essential supervisory and regulatory principles that all countries should implement. These include governance issues, prudential requirements, information exchange, and sanctions. A number of supporting documents, called IAIS standards, have also been subsequently developed for activities like licensing, on-site inspections and investing in derivatives and new standards continue to be developed in areas like reinsurance, solvency margin requirements and the like.

Assessing the ICP – who and why

The assessment of the insurance supervisory system under the Financial Sector Assessment Programme (FSAP) under the aegis of International Monetary Fund (IMF) and the World Bank, and with the participation of IAIS in the case of insurance sector, aims at

identifying gaps in insurance sector regulation and supervisory practices and providing input for the overall stability assessment of the financial system.

The main instrument used to achieve these objectives is assessing how well insurance regulators observe the ICP (which was issued by the IAIS in 1997 and revised in 2000.) This is combined with the risk analysis of the broader financial system to establish the vulnerabilities in the insurance sector.

How the assessment is done

A range of tools is used in undertaking the assessments, the most important being the methodology. The methodology requires an assessment of supervisory processes not to be done in isolation, but after taking into account the risks and vulnerabilities from macroeconomic developments facing the insurance sector.

Active use is also made of any self-assessments done by supervisory authorities prior to the financial sector assessment, relevant laws and regulations, interviews and discussions with supervisory authorities, other

domestic regulatory bodies, groupings of actuaries, accountants, and auditors, and licensed insurance firms. To establish cross-sectoral linkages and form a view on overlapping issues, the assessors also discuss their findings with the banking and securities regulators.

The assessments recognise that supervisory processes in different countries often reflect the local culture and attitude towards insurance, as well as the national authorities' ability to rely on the work of insurance accountants, auditors, and actuaries. In some cases, therefore, the assessors modify the minimum set by the methodology and assess the country against the standard that the assessor feels the country should achieve.

In many cases, they interpret the ICP in slightly different ways. Differing interpretations should, however, get minimised as the IAIS progressively sets supervisory standards underlying the ICP.

Assessors are strengthening the macroprudential analysis underlying the supervisory framework. Recent assessments have begun making

Strengths...

Supervisory areas in which country practices assessed are generally satisfactory with respect to the ICP are: financial reporting; cross-border business operations; capital adequacy and solvency; sanctions; prudential rules—liabilities; and, confidentiality.

The most commonly identified strengths in these areas are:

- (i) Financial reporting: Financial reporting requirements are set within the country and companies are required to file financial reports with the supervisory authority at least quarterly; audited financial reports were required annually.
- (ii) Cross-border business operations: All foreign companies are required to be licensed to sell insurance in

the country.

- (iii) Capital adequacy and solvency: Supervisory authority is able to prescribe capital and solvency standards that companies are required to meet.
- (iv) Sanctions: Many supervisory authorities have broad powers and a wide range of sanctions ranging from fines to licensing restrictions and de-licensing. Supervisors, however, often have limited discretionary powers and can only apply sanctions in the event that the company violates the law.
- (v) Prudential rules—liabilities: Supervisory authorities can set the basis for the valuation of liabilities. This is done either directly by the supervisory authority, through another branch of government, or through a domestic actuarial standard-setting body. The

satisfactory assessment of the supervisory practices relating to liabilities is due to the fairly accommodating wording of the ICP. The formulation is broad enough to capture a wide range of established practices. To observe the principle, a supervisory authority must have powers to set the method and basis for the valuation of policy and other liabilities. However, the principle does not require that the authority be applied to any particular prudential standard. This is an important area that requires more work.

- (vi) Confidentiality: Staff of the supervisory authority is subject to professional secrecy requirements, and required to maintain the confidentiality of supervisory information.

systematic use of insurance-related financial soundness indicators to assist in the analysis of the insurance supervisory vulnerabilities. These include: ratio of the liabilities of life insurance companies to total bank deposits; ratio of the government bonds held by the insurance industry to the outstanding domestic debt; and ratio of total insurance premiums to GDP.

Assessment of Preconditions

The methodology identifies a set of preconditions for effective insurance supervision. These include: a sound legal and accounting system; procedures for resolving problems in insurance companies; effective market discipline; and sound and sustainable macroeconomic policies. There is, however, no explicit supervisory principle in the ICP document relating to the overall framework of insurance supervision.

While recognising the shortcomings in the overall conditions of insurance supervision may significantly impair the ability of the insurance supervisor to implement the principles, the methodology requires assessors to evaluate the degree to which the

identified preconditions are met and indicate potential problems stemming from any shortcomings.

The methodology, however, does not prescribe a basis to evaluate these preconditions. This remains a major limitation of the ICP and the methodology, particularly as these preconditions cover issues that are generally outside of the control of the supervisor (operational independence, political interference, legal protection for supervisors). Future assessments should consider actions that supervisors can take to mitigate the effect of the preconditions that are not fully satisfied.

The assessments of the preconditions for effective insurance supervision made by IMF and World Bank reveal that countries in some jurisdictions partially met the preconditions for effective insurance supervision, with qualifications related to the fact that while good laws were either in the process of being adopted or recently passed, they have not been tested in practice, or that the familiarity with the laws was weak. In many countries, the judicial system remains weak, laws are outdated, and there were

few qualified professionals (i.e. actuaries, accountants, auditors, and financial analysts. (See box items below.)

Stage of development of insurance sector

Economies where insurance plays a bigger role in the financial system can have a far greater impact on financial stability than in countries in which it is underdeveloped. The degree of observance of ICP in countries in different intermediate stages of development of the insurance industry is quite similar, but significantly lower than that of countries with the more developed insurance sectors.

Countries with poorer insurance penetration were found more often as not observing the ICP in the latter set of areas listed above in countries than countries with more developed insurance sectors.

ICP and transparency

In conjunction with the ICP assessment, assessments are also being made of the transparency practices of

and weaknesses

Areas in which supervisory practices were identified as weak include: Organisation of an insurance supervisor; changes in control; corporate governance; internal controls; prudential rules-assets; reinsurance; market conduct; and derivatives and off-balance sheet items. The most frequently cited shortcomings in the implementation of the principles in these supervisory areas were:

- (i) Organisation of an insurance supervisor: Weak institutional capacity characterised by inadequate supervisory skills and staff numbers, lack of financial resources and operational independence, and a nontransparent accountability framework.
- (ii) Changes in control: The supervisor is often notified in advance but: there are no clear criteria for denying a change in control; supervisory approval is not required or the

supervisor has no authority to deny a change in control. In some cases, the supervisor is not notified in advance of a change in control.

- (iii) Corporate governance and internal controls: Lack of a description of the role and responsibilities of the board of directors of insurance companies in relevant legislation and regulations; and supervisors do not have the authority to define the role of directors. The most commonly identified reasons for non-observance or less than full observance of the principle on internal controls is the need to establish or strengthen risk management, asset-liability matching, and the supervisors' lack of authority to enforce an internal control regime in companies.
- (iv) Prudential rules—assets: Need to strengthen the investment rules and exposure limits for assets. In a few cases, the concern is that the investment rules were too limiting for reinsurance companies, which
- constrained the development of the market.
- (v) Reinsurance: In all but one case, the identified shortcomings related to the inadequacy of the supervisors' power to review or set standards for the use of reinsurance by direct-writing companies. In some instances, the supervisory authority needed greater power in setting retention limits (that is, a limit on the insurance risks that the direct-writing company would keep before seeking reinsurance protection).
- (vi) Derivatives and 'off-balance sheet' items: Need to define or strengthen the rules for the use of derivatives and the disclosures made by insurance companies in respect of their use of these instruments.
- (vii) Market conduct: Need to ensure that insurance companies establish a complaint-handling system and supervisors need to have their role clarified and strengthened in this area.

the insurance supervisor. The assessment is undertaken with reference to the *IMF's Code of Good Practices on Transparency in Monetary and Financial Policies (MFP Transparency Code)*. A high degree of observance of ICP is associated with the high degree of observance of the MFP Transparency Code in the area of insurance and supervision and vice-versa.

Transparency practices of insurance supervisors are strongest in the area of public availability of information on financial policies, whereas transparency practices related to assurances of integrity of the insurance supervisor are most deficient. The most commonly

identified shortcomings include: internal governance procedures are not publicly disclosed; and co-operation and information-sharing agreements with other supervisory agencies are not transparent.

Implications for financial sector vulnerabilities

The ICP assessments are being used by the IMF as input into the stability assessments and by the World Bank in the assessment of the overall development needs of the financial system. The assessment findings reveal several potential sources of supervisory risks and vulnerabilities.

Two issues affecting stability have

emerged. First, several assessments have noted the stability risks emanating from weakness in the supervisory co-ordination among insurance, banking, and securities supervisors. While this is mainly in the case of countries where financial conglomerates exist or are gaining importance, the findings have a general application. The insurance supervisor needs to monitor, along with other sector supervisors, the systems for risk identification and risk management across financial groups.

A second area relates to strengthening the regulations relating to the prudential framework and its enforcement. These relate

IAIS' Insurance Core Principles

Organisation of an Insurance Supervisor (ICP 1): The insurance supervisor of a jurisdiction must be organised so that it is able to accomplish its primary task, i.e., to maintain effective, fair, safe, and stable insurance markets for the benefit and protection of policyholders. It should, at any time, be able to carry out this task effectively in accordance with the Insurance Core Principles.

Licensing and Changes in Control (ICPs 2, 3): Companies wishing to underwrite insurance in the domestic insurance market should be licensed and the insurance supervisor should review changes in the control of companies that are licensed in the jurisdiction.

Corporate Governance and Internal Controls (ICPs 4, 5): It is desirable that standards, which deal with corporate governance, be established in the jurisdiction. The supervisor should be able to review the internal controls and require the board of directors to provide suitable prudential oversight.

Prudential Rules (ICPs 6, 7, 8, 9, 10): Insurance companies should meet prudential standards established to limit or manage the amount of risk that they retain. Standards should be established in the areas of assets, liabilities, capital adequacy and solvency, derivatives and "off-balance sheet" items, and reinsurance.

Market Conduct (ICP 11): Insurance supervisors should ensure that insurers and intermediaries exercise the necessary knowledge, skills, and integrity in dealing with their customers.

Monitoring and On-Site Inspection (ICPs 12, 13): Insurance supervisors should get the information they need to properly form an opinion on the financial strength of the operations of each insurance company in their jurisdiction.

Sanctions (ICP 14): Insurance supervisors must have the power to take remedial action where problems involving licensed companies are identified.

Cross-Border Business Operations (ICP 15): The insurance supervisor should ensure that: no foreign insurance establishment escapes supervision; all insurance establishments of international insurance groups and international insurers are subject to effective supervision; the creation of a cross-border insurance establishment is subject to consultation between host and home supervisors; and foreign insurers providing insurance cover on a cross-border services basis are subject to effective supervision.

Co-ordination and Co-operation (ICP 16): In order to share relevant information with other insurance supervisors, adequate and effective communication should be developed and maintained.

Confidentiality (ICP 17): All insurance supervisors should be subject to professional secrecy constraints in respect of information obtained in the course of their activities.

particularly to liabilities, where weak supervisory practices and requirements could conceal institutional weakness. In several cases, the ICP assessments cited the interconnectedness of financial institutions (insurance companies and banks) as having the potential to lead to a systemic problem. In one case, the issue highlighted was the failure of the supervisor to sign memoranda of understanding (MOUs) with foreign supervisors, given that foreign companies owned most of the insurance companies.

Interestingly in a few cases, the assessments have not raised any stability-related concerns despite the countries' low level of observance of the ICP. This is due to the small size of the insurance sector relative to the other constituents of the financial system.

Assessment recommendations

ICP assessment identifies areas in which the supervisory authority should make changes to strengthen insurance supervision. ICP assessment recommendations have two objectives:

- (i) to strengthen supervisory practices where weaknesses are identified; and
- (ii) to raise the quality of insurance supervision in areas where, even though countries met the requirements of the ICP, additional steps could further foster the development of a sound insurance sector.

An analysis of the supervisory areas where recommendations are most frequently made is undertaken by

groups of countries based on the stage of development of their insurance sectors. The patterns in the clustering of recommendations by broad areas of supervision support the view that assessors have addressed both objectives of this part of the assessment process.

While some of these recommendations address shortcomings in observance of the ICP, others attempt to raise the quality of insurance supervision above the prescribed minimum. The most commonly made recommendations related to organisation of an insurance supervisor, licensing, prudential rules, and corporate governance.

- **Organisation of an insurance supervisor:** Increase the number of staff in the authority; improve the quality of staff (training and recruiting) and the supervisory framework; enhance the independence of the supervisor; strengthen indemnity of the supervisory staff.
- **Licensing:** Increase the supervisor's authority and role; strengthen licensing criteria; tighten up the rules on composite companies; set rules for changes in control to be similar to licensing requirements.
- **Prudential rules:** Strengthen investment rules and limits; upgrade rules for valuation of liabilities; strengthen capital requirements; define rules for the use and disclosure of derivatives; enhance supervision of reinsurance arrangements.

- **Corporate governance:** Clarify or define what is expected of boards of directors; establish risk management practices.

The degree to which the assessment process has the support from each country and the extent to which the national authorities are willing to take corrective action is an important part of the FSAP process. Feedback from national authorities shows that the assessment process has been found to be useful in the implementation of the ICP. The assessments have provided impetus and direction to national authorities' ongoing efforts to bring their insurance legislation and regulatory framework in observance with internationally accepted supervisory practices.

Several countries report difficulties in the implementation of the principle relating to corporate governance. This is mainly due to the lack of development in the local standards of general business practice or legislation. The "fit and proper" test and "co-ordination and co-operation with other supervisors" are also mentioned as being difficult to implement by a number of countries. In addition, some countries have reported resistance on the part of the insurance industry to make changes in regulations introduced as a consequence of the recommendations based on the ICP assessment.

(The second part of this article will be published in the February issue.)

The author is Deputy Director, IRDA.

"Consumer education is going to be the most significant area in the next 4 to 5 years. I believe that growth in the industry will come through consumer education among the middle class. We have to tell them what they are missing.

There is no sustained campaign on what insurance does. Who is doing it? If companies are reluctant to do it because of costs then the regulator has to do it."

N. Rangachary,
Chairman, IRDA



Fighting Fraud

R.C.Sharma

Crime in its diverse manifestations such as fraud, money laundering, swindling and forgery, is all pervading in different financial activities in many ways. It embodies all the mechanisms by which human beings are tempted to make material gains through false dealings.

White-collar crime is on the rise and instances of fraud in the financial sector are quite numerous. Most frauds against corporations are not committed by strangers but by people who have some kind of relationship with the organisation.

The insurance industry is rampant with fraudulent activities that cause great damage to its development.

Fraud in the industry may be committed by an insurer itself and its allied entities, but it can also be perpetrated by the consumer.

Insurer and its allied entities may resort to frauds by way of wrong investments and dubious transactions. The consumer (policyholder) may take to cheating and money laundering.

Insurers and agents can defraud customers, or even each other. Insurance fraud is hard to measure because so much goes undetected and complete research has just not been done. Still there is enough evidence to establish that fraud is widespread and expensive.

Some of the manifestations of international insurance fraud, which is ubiquitous in nature, are as under.

- Fabricating the subject matter of insurance
 - Falsifying the causes of losses
 - Exaggerating the losses incurred
 - Transforming the non-subject matter of insurance into the subject matter of it
 - Concealing the truth concerning the subject matter of insurance
 - Inducing the occurrence of incidents
- Fraudulent financial reporting

results in losses and this can create various kinds of victims. They can be the holders of the corporation's debt and equity securities, investors, depositors, shareholders, suppliers and customers. The company's management and directors could be affected. Public share holders, honest employees and managers whose careers may also suffer can be called victims as well.

Management is also responsible for integrity of the corporation's financial statements. Weak internal controls provide opportunities for financial frauds.

Another area where fraud is possible and rampant is investments. Insurers are supposed to invest as per the regulations laid down for the purpose. But this is the broad area where insurers can try to conceal things and

Technological developments, while they have helped in improving the functions of the companies and expediting their data collection, have also contributed to creating new avenues for the fraudulent.

may try to escape the watchful eye of the regulator / supervisor.

Most insurance companies take a tough stand against fraud, but some companies unwittingly encourage fraud by paying suspicious claims too easily. These companies believe that it is cheaper to pay some smaller, suspect, claims, than to fight them in court, and also that a quick payout may avoid costly law suits for bad faith. Some of them may even coerce the policyholders to settle for reduced claims. Insurance cheaters view insurance fraud as a low-risk, high-reward, game and far safer than a lot of other nefarious activities.

Technological developments, while they have helped in improving the functions of the companies and expediting their data collection, has also contributed to creating new avenues for the fraudulent. Use of the Internet, e-transfer, credit cards and similar technology-based instruments for making transactions has placed another tool in the hands of those who are deft at the art of manipulation and money laundering.

The scene of financial crimes in India, more so in the insurance sector, is no better than that in other countries doing the business. It requires to be minutely watched at all levels and subject to stringent actions at all stages.

Regulators in general are seized of the situation and endeavour to contain the crime by means of putting up different regulations in place and sounding warning bells to cope with this cancerous phenomenon.

The insurance regulator in India has, among other measures, put in place the following regulations to control the insurance business and ward off possible fraudulent transactions.

- Insurance Advertisements and Disclosure Regulations
- Protection of Policyholders' Interests regulations
- Prescription of code of conduct for different intermediaries

In addition to regulatory measures, many other ways and means need to be deployed to keep in check dubious transactions.

Most frauds are discovered by accident in the sense that someone is not working on a project to detect frauds. A manager might notice something that does not seem right and a follow up uncovers fraud.

Fraud examination is a relatively new, but growing, discipline. The basic concept of fraud examination is that it is most likely to occur where there is opportunity, motive and people of questionable integrity. Ongoing fraud

auditing programmes act as deterrent to fraud. Fraud auditing focuses on motive and opportunity.

Fraud is not easy to find. The fraud examiner has to understand the customers, markets and corporate culture. In a sense, he has to know as to what is within the realm of normal activity. When something is found outside this realm, it may be a clue to search for possible fraud.

Most insurers around the world have made fighting fraud a priority and have created special fraud busting units. They actively educate consumers about how to detect and guard against fraud. Countries have even enacted laws which impose stiff prison terms and fines for white-collar criminals who loot insurance companies.

Money laundering is a technique of legitimising income arising from illegal or criminal activities. Insurance is one of the major areas vulnerable to money

laundering activities. In order to curb money laundering, it is imperative for insurance supervisors to

- conduct onsite compliance visits
- exchange information with national and international law enforcement authorities, and
- take account of the extent to which an insurer has taken anti-money laundering steps.

Insurance entities are required to have a constant vigil against attempts at money laundering. They are supposed to be very particular about the following:

- Various checks at the stage of underwriting
- Verification
- Recognition and reporting of suspicious customers / transactions
- Keeping records
- Register of inquiry
- Training

Despite efforts to keep it in check, insurance fraud will remain a vast and paying criminal enterprise. Everyone pays for insurance fraud and so everyone must join in stamping out these swindles. Consumers, lawmakers, insurance companies, doctors, lawyers and many more must be part of the answer.

Insurance fraud will disappear only when criminals realise fraud is a fast highway to jail, not an easy road to riches.

The author is Assistant Director, IRDA.

The IAIS and the IRDA are holding an international conference on fraud and anti-money laundering. See page 9 for details.

Keeping an Eye Open

The Financial Action Task Force (FATF), an inter-governmental body consisting of 29 countries and 2 international organisations formed to develop and promote policies to combat money laundering, has put forward forty recommendations towards this end.

Because of the diverse legal and financial systems of different countries, the recommendations cannot be applied universally. Therefore these are suggestive in nature. The gist of some of the important recommendations is:

- Countries should take steps against drug trafficking
- Financial institutions should not entertain anonymous customers or those with obviously fictitious names
- They should keep a watch on all complex and unusual patterns and large transactions
- Financial institutions and their officials responsible for detection of such transactions should be protected by legal provisions from criminal and civil action for breach of any restrictions
- Financial institutions should give special attention to business relations/transactions with parties from countries which do not, or insufficiently, apply these recommendations.

The International Association of Insurance Supervisors (IAIS) has laid down Insurance Core Principles for its members to follow to the extent possible. As per the guidelines contained therein, an insurance supervisor is expected primarily to protect policyholders and promote a secure and efficient market by ensuring that companies comply with the legislation and regulations governing the business of insurance.

One of the key methods for the insurance supervisor to act against fraud is sanctions. Sanctions (embodied in Principle 14) provide for withholding approval for new activities, stopping practices that are unsafe and other remedial measures.



The difference between this group of participants and those in previous years is that we have younger people and from more varied fields, not just insurance. There are no senior executives from public sector companies.

– S. V. Mony, CEO,
AMP Sanmar Assurance Company,
summing up the CII Summit
proceedings.

'Award can be more than claim'

The Supreme Court has ruled that there was no bar on Tribunals and Courts under the Motor Vehicles Act to restrict the award of compensation to the amount claimed by the victim in his suit.

"Under the provisions of Motor Vehicles Act, 1988, there is no restriction that compensation could be awarded only up to the amount claimed by the claimant," a Bench comprising Justice M B Shah, Justice B P Singh and Justice H. K. Sema said, enhancing the compensation by Rs.1 lakh to a villager, whose leg had to be amputated due to an accident.

The Bench also said that in an appropriate case where, from the evidence brought on record, the Tribunal/court considers that the claimant is entitled to get more compensation than claimed, the Tribunal may pass such an award provided it was 'just' compensation and was neither arbitrary, fanciful nor unjustifiable from the evidence.

One Mr. Nagappa, the victim of a road accident, was awarded a compensation of Rs 30,000 by the Tribunal and the High Court had enhanced it to Rs 82,000 and an additional Rs 18,000 was granted for the purchase of an artificial leg.

Later the victim realised that the artificial leg had to be changed every two years but had no money for it and made a plea for grant of compensation to meet his recurring medical expenses.

In a case where injury to a victim requires periodical medical expenses, a fresh award cannot be passed or a previous award be reviewed when the medical expenses are incurred after finalisation of the compensation proceedings. The only alternative is that at the time of passing of final award, the Tribunal/Court should consider such an eventuality and fix compensations accordingly, Justice Shah said.

Banks cannot become brokers

The IRDA has made it clear that banks cannot become insurance brokers and can only function as corporate agents selling the products of one life and one non-life company.

For banks to become brokers, which status enables an entity to distribute products of more than one insurer, the Banking Regulation Act needs to be amended.

Though many banks have tied up with insurance companies to distribute insurance products through their widespread branch network, bancassurance has not really taken off in the country yet.

LIC to cover women's ailments

Life Insurance Corporation of India (LIC) is to launch a policy for women to cover them against diseases unique to them.

It is finalising the terms with reinsurance companies and will launch the policy shortly.

LIC has several policies for women including one for working women launched last year. But none of these policies is exclusive to women in the sense that men too can take the policy.

Safe shopping!

Rediff.com, the news and shopping portal, has insured against fraudulent credit card transactions on its website with United India Insurance Company Ltd. Users of the portal, which offers online shopping, will be protected against the fraudulent use of their credit cards up to Rs. 10,000 per transaction for any product purchased on the website.

Many users, according to the website company, fear using their credit cards for online transactions and prefer the cash on delivery option instead. This cover is meant to resolve this situation.

Claims arising out of the fraudulent use of credit cards will be refunded within 15 days on receipt of the information. The insurance is available only for transactions by Indian nationals.

JB Boda is Lloyd's broker

JB Boda group's UK-based operation has received provisional accreditation as a Lloyd's broker.

One of Asia's oldest and largest insurance brokers, the group has had a presence in the UK market since 1967. It operates in India as a reinsurance broker and, following the IRDA's announcement of brokers' regulations and calling for applications, plans to enter the direct broking business here both in life and non-life businesses.

Database of refused lives

The Tariff Advisory Committee (TAC) is planning to create a database of 'refused lives' for the use of life insurance companies, a facility that will help the latter take prudent underwriting decisions. The facility will be provided to the insurance industry free of cost as part of TAC's ongoing obligations to it.

The concept is that life insurers should share a negative list of lives they cannot insure so that one insurer does not wind up unknowingly insuring a life that has already been declined by another insurer as a bad risk and hence uninsurable.

The TAC, which will function as a data warehouse to the industry in the future, has created the information technology infrastructure needed to collect and maintain such data, and allow retrieval by insurers as well.

Life insurers have been asked to participate in the database by submitting voluntarily to the TAC information about any proposals they have declined to underwrite. This information is gathered at one point and kept confidential, so that it can be accessed by other life insurers who are faced with a proposal they have doubts about entertaining.

Mr. T. R. A. Krishnan, Regional Manager, TAC, Chennai, who also leads the statutory body's information technology initiative made a presentation to the life insurance company chief executives and appointed actuaries on December 16, 2002, at Hyderabad during a meeting of the Life Council about the new project.

Data on cancellation of insurance contracts for the same reasons as declination will also be collected and be available for retrieval he said. The TAC

will also be providing various analyses of the data on declined lives periodically.

A proposal on a life is said to be declined if an insurer refuses to insure it for any reason. In most cases it is health, but other reasons could be occupation, hobbies, criminal records or activities, insolvency, financial reasons and the like.

Once insurance companies input data on the lives they have declined, other companies can query the system giving the name and other details of proposals they have received and that they want to know about. The system will provide them with only a specific reply as to whether the name queried is in the declined list and what the reason for the declination is.

Initially the data will be available on request by e-mail from the TAC, and later an online search/query system is to be put in place.

TPAs and additional fees

Some Third Party Administrators – Health Services (TPAs) are charging medical insurance customers who go to them for settlement of claims an additional fee in addition to the insurance premium

This practice has started due to the fact that many licensed TPAs have not been empanelled by any insurance company yet and need to charge the customer seeking their services for claims settlement in order to survive.

The IRDA has clarified to insurers and TPAs that in the case of all such agreements which are out of the scope of IRDA (Third Party Administrators – Health Services) Regulations, 2001, and adequate precautions must be taken by informing the customer clearly of this fact.

In all such agreements, where customers seek separate services outside the ambit of the insurance contract, the scope of such services need to be outlined and a specific mention made that since it is out of the scope of the IRDA's regulations, the customer shall be solely responsible in case of any deficiency of service.

GIC opens reinsurance account

THE General Insurance Corporation (GIC) has begun writing reinsurance business in other markets by providing reinsurance cover against earthquake risks to general insurers in Israel, Greece, Turkey and West Asia. The newly designated Indian reinsurer is venturing into other markets and acting as reinsurer to other country general insurers for the first time.

Most of the new deals are in the nature of co-insurance and the sum insured in these deals are estimated to be in the region of about Rs 100 crores.

There is scope for entry of new reinsurers like the GIC into the market at a time like this since the big

reinsurers like Munich Re and Swiss Re have been facing a shrinkage of capacity following the 9/11 losses and those arising out of European floods.

GIC was chosen as co-insurer since it is adequately capitalised and has a high rating. GIC has been playing it cautiously since it is yet new at the game and has chosen exposures where the probably maximum loss is low. It is also thinking of setting up joint ventures with companies in West Asia and Israel for more international participation. GIC is also beginning to explore markets in the Far East, including China, and eastern and western Europe through its overseas offices.

Lowest Growth in Premiums Since 1980s

A new Swiss Re Sigma report released early December concluded that overall global premium income reached \$2.408 trillion in 2001. Though the numbers are high, it is only a one per cent growth over 2000 and, in fact, is the lowest growth rate recorded since the beginning of the 1980s.

The life insurance sector recorded premiums of \$1.439 trillion, while the property and casualty sector accounted for \$969 billion. Adjusted for inflation, life premiums which had been growing well in the recent years, actually fell by 1.8 per cent while non-life premiums grew by 5.4 per cent - the highest growth in 10 years.

The study cited the combination of continuing turbulence in the financial markets and a high claims burden as the main causes for the relative decrease in growth last year.

The recent boom in the life insurance market came to an abrupt end due to the 2001 stock market downturn which lowered the demand for unit-linked insurance products, said Swiss Re. This was only partially offset by increased demand for life insurance with guaranteed returns and pension provisions. Some increase in life premium volume this year is foreseen.

The non-life sector showed a different picture. The recovery seen in 2000 accelerated through 2001 in terms of premium income. In particular, rate increases were achieved in the highly competitive commercial insurance and motor lines, where premiums saw a considerable boost. The trend is continuing this year. The report also noted that in the industrialised countries, premium growth in 2001 was clearly above the long-term average. In the emerging markets too, premiums overall were up on previous years.

But despite clear price increases, non-life insurers' profitability suffered significantly in 2001 due to claims from the September 11 attacks, reserve-strengthening from the days of the soft-market and falling investment returns due to share price collapses.

As in the life insurance business, these factors considerably depleted equity in the non-life markets, thereby weakening insurers' balance sheets.

Environmental insurance planned

Scientists are devising a plan for the introduction of environmental insurance for businesses like developers and agricultural importers.

James Cook University's Professor Steven Garnett has aired the idea at the Ecology 2002 conference in Cairns.

Professor Garnett says its introduction would cover eradication costs in the event of unwanted pests or environmental degradation and act as a deterrent to irresponsible behaviour.

"Underpinning everything we do is the water, the soil, the air [and] that's what we're trying to insure," he said.

"Often it's government money, it's the public purse which is doing that insurance, or else the environment suffers and future generations suffer."

HIH investigation over

The Royal Commission which has been investigating the failure of Australia's second largest general insurer, HIH, ended its work in early December after 200 days still uncertain about whom to blame.

Submissions will follow in the case where billions of dollars are missing, and the then commissioner Neville Owen has until February 27 to explain Australia's worst corporate catastrophe.

HIH declared bankruptcy in March 2001 with debts estimated at \$5.3 billion. Its founder and chief executive Ray Williams, and executives Mr. Rodney Adler and Mr. Brad Cooper, who came into the HIH fold after Mr. Williams bought the Adler family company FAI in 1999, have been charged with insider trading of HIH stock.

Mr. Adler, now serving a 20-year ban from company directorships over his use of

HIH money, denies any knowledge of the affair. Mr. Cooper has confessed.

Justice Owens' report will also decide the fate of Arthur Andersen, for long the auditors of HIH, who have been charged with negligence.

The Australian Prudential Regulation Authority (APRA), which finally appointed an inspector to HIH on March 15, 2001 - the same day the liquidator KPMG pulled the plug - is also likely to be criticised because it has been accused of being under-staffed, under-funded and under-responsive to the HIH alarm bells.

The commissioner is also to make recommendations for policy reform. Though his recommendations will be non-binding they are likely to play an important role given the attention corporate governance is getting these days.

Sri Lanka to sell state insurer

Sri Lanka aims to sell off a state-run insurer - Sri Lanka Insurance Corporation (SLIC) - by finalising the bid shortly.

The sale of majority stake in SLIC will be the biggest privatisation in the Sri Lankan Government's quest to meet the privatisation target of \$ 220 million. Four investors are expected to present bids for a 90 per cent stake in SLIC and the successful bidder is to be selected by end December, Mr Deepal Gunaratne, Director General of the Public Enterprise Reform Commission has said.

HEALTH INSURANCE FOR THE POOR

The International Labor Office (ILO) and the World Bank have got together to solve the problem of health insurance for poor people.

A programme being implemented in the Philippines involves adding a reinsurance backstop to small, regional insurance plans to guarantee their solvency through periods of extreme need.

Since the poor are bad health risks, and since they cannot pay premiums, private insurers rarely offer them coverage. With only public or charitable healthcare systems open to them, poor people lose out on the advantages of insurance and their healthcare needs are poorly met.

Small regional insurance plans do provide some protection but they do not have the financial stability and solvency when faced with claims from epidemics or health catastrophes. The ILO – World Bank effort is to demonstrate the positive impact of the small plans and the practical potential for reinsurance.

And the results are showing. In the five regions where this scheme is on, hospital visits were 40 % higher as was compliance with drug regimens for the chronically ill and mortality rates for microinsurance members were substantially lower in the last five years than mortality rates compiled from regional statistics.

Under the scheme, the small insurance plans pay premiums to a central fund each year. If a plan is unable to cover its losses in a given year, the central fund would pay out an award — the equivalent of a regular insurance claim — to bail it out.

The Filipino programme is the most extensive microinsurance effort yet made and requires an initial injection of capital to take care of catastrophic

losses in the first few years before the plans' reinsurance premiums accumulate.

This capital is only about \$9 million, yet money to start the reinsurance programme has not been forthcoming either from the government, independent donors or private insurance companies. This is because of the belief that the poor are uninsurable and also because the amounts needed are too small to even make the minimum quantum for infrastructure investments.

So the programme's organisers have paid for training and administration in the Philippines so far, but neither has a mandate to provide the start-up funds.

One technical issue is that when all the insureds are concentrated in one area whatever the risk is, there are always possibilities of high correlation.

Once reinsurance systems are in place, microinsurance units in villages all over the world could protect each other from epidemics, with a slim chance that all would befall the same catastrophe at the same time.

Terrorism backstop - reality sinks in

The US terrorism backstop legislation needs only President Bush's signature, but the move which was much sought after by business, specially the construction business, has begun raising a lot of questions on the part of insurers.

One main thing is that the bill federally regulates the forms of surplus carriers and this is a first time for the industry.

The whole industry has to quickly learn to price the terrorism component of their policies because the cover is mandatory now and they will have to sooner or later write the business.

Another thing is that the terrorism cover will now have to be offered without exclusions that used to be imposed earlier.

This, apart from the obligation to give the cover, means insurance carriers have to work on the pricing aspect.

The exclusions can be reinstated but that is only after a 30 day period given to the insured to study and reject the pricing. The catch is that the insurer is on risk for that period.

Another question is about the provision in the legislation that says that insurers have to offer terrorism coverage on all lines. While

this is fairly clear for property insurance, on the casualty side which includes medical malpractice, Directors and Officers Liability and the like it requires clarifications, feel insurers.

Asbestos suits

Asbestos lawsuits have cost US businesses as much as \$275 billion and have resulted in the loss of about 55,000 jobs, according to a report that the American Insurance Association released in early December.

The report examines the cost of business bankruptcies associated with asbestos litigation. During the first 10 months of 2002, 15 companies that faced significant asbestos-related losses filed for bankruptcy, more than the total of asbestos-related bankruptcy filings in any five-year period before 1999, the report notes.

Asbestos is a carcinogen used as insulation and fireproofing in applications that range from homes to factories. When inhaled, the

fibres can cause various respiratory ailments, including lung cancer.

With more than 2,00,000 asbestos-related claims pending before U.S. and state courts, the compensation problem has become complex. The estimated liability for U.S. businesses is more than \$200 billion, according to the Rand Institute for Civil Justice, a research group in Washington.

The association report says asbestos-related lawsuits harmed workers and shareholders in companies that were sued and forced into bankruptcy, as well as employees vested in company retirement plans.

Companies employing more than 2,00,000 people the year before have filed for Chapter 11 bankruptcy protection.

The association and other business groups want legislation to protect companies facing asbestos lawsuits.

But many workers exposed to asbestos have little sympathy for them. They say the companies' negligence caused the illnesses and deaths of thousands.

Role of brokers

The Federation of Andhra Pradesh Chambers of Commerce and Industry (FAPCCI) in association with GVR Risk Management Associates (P) Ltd. held a one day "Seminar on Insurance Intermediaries/Brokers - their Services to Customers and Insurers" on December 14, 2002, at Hyderabad.



Mr. Omprakash Tibrewala, President, FAPCCI, and Mr. N. Rangachary, Chairman, IRDA, at the Seminar inaugural.



L to R: An official of Microsoft (India), Mr. N. Rangachary, Chairman, IRDA, Ms. Ritu Nanda of RNIS College of Insurance and Mr. K. K. Srinivasan, Secretary, Tariff Advisory Committee.

Microsoft & insurance

Microsoft (India) held a one day 'Insurance Event' on December 9, 2002, in Mumbai, showcasing its insurance-related products and services.

Training at IRDA

A Financial Statement Analysis Training programme is being held by the International Insurance Foundation (IIF), Washington DC, for the staff of the IRDA. The training includes on-site inspection of insurance companies.

Faculty members included Mr. Paul SuMitra, Program Director, India, IIF, Ms. Marianne K. Burke Director of the Division of Insurance, IIF, from 1995 till her retirement in 1999, Dr. Robert Gibbons, Executive Director and President, IIF, and Mr. Neeraj Gupta, Chief Examiner, Oregon Department of Consumer and Business Services.



L to R: Ms. Rama, Mr. R. C. Sharma, Mr. S. N. Jayasimhan and Mr. Arup Chatterjee, all officers of the IRDA, with one of the Seminar leaders Mr. Paul SuMitra.

Event?

Send us a write-up!



L to R: Mr. N. Rangachary, Chairman, IRDA and Dr. C. Rangarajan, Governor of Andhra Pradesh with a copy of the newly launched Journal.

The IRDA Journal was formally launched by Dr. C. Rangarajan, Governor of Andhra Pradesh and former Governor, Reserve Bank of India, at a function at Raj Bhavan, Hyderabad, on December 4, 2002.

Dr. Rangarajan said that the Journal must be informative and analytical. The growth of the industry as a user-friendly one would be through the regulator playing its role and the Journal voicing the concerns of the industry and the consumers.

Mr N. Rangachary, Chairman, IRDA, said that the Journal was the culmination of the regulator's credo of transparency, and that participation and communication were key to that.



L to R: Dr. C. Rangarajan, Governor of Andhra Pradesh, Ms. K. Nitya Kalyani, Editor, IRDA Journal, Mr. N. Rangachary, Chairman, IRDA, Mr. R. C. Sharma, Member (non-life), IRDA.

Launched!



Birla Institute of Management and Technology brought out the inaugural issue of its *Journal of Insurance and Risk Management*. The institute, which has a post-graduate diploma programme in Insurance and Risk Management and a Doctoral programme in Insurance, and has created this Journal as "a discussion platform for the leaders of the industry, policy makers and academicians."

The Journal's Editor-in-Chief, Dr. H. Chaturvedi, promises in his editorial that it will "develop innovative models in insurance and risk management through research and conceptual writings," and invites theoretical and applied research papers in these areas. The Journal has as its Editor Mr. D. C. Srivastava and as Managing Editor Mr. Rahul Singh.

Event?

Send us a picture!

Dear Editor

The journal has come out very well, and I congratulate you for that.

The Statistics section has come out very neatly. One suggestion. If you could think of giving earlier data on many of these parameters, then it will be useful for researchers. As much past data as possible can be given in an issue, since past data is very difficult to get in these cases. Once you give past data in one issue then that can be referred to in later issues.

I am really happy about the News Briefs and Round Up sections since it would be very useful for practitioners. Incidentally the article on the Cover Story was informative and incisive.

R.Vaidyanathan

National Fellow [ICSSR] & Chairperson
Centre for Insurance Research and Education [CIRE]
Indian Institute of Management, Bangalore

Hearty congrats on getting the IRDA Journal off the ground. I am sure it will be a path-breaker and fulfill the need of the industry.

I am sure it will also serve those who are not in the industry, but avail of the industry's services.

I wish the Journal all the best.

Srinivas Acharya

Managing Director
Lakshmi General Finance Ltd.
Chennai

I was honestly fascinated by the quality of the journal released by your esteemed office. I request you to provide me with an extra copy - hope it is available electronically.

K.Chandrashekar

AMP Sanmar Assurance Co. Ltd.
Chennai

I have gone through the IRDA Journal. I would like to offer you my wholehearted congratulations for such a brilliant effort. There are a few areas however, including the one on the format of the journal, which could be strengthened.

Ashvin Parekh

Executive Director
Deloitte Touche Tohmatsu

I congratulate you for the excellent work on the IRDA Journal. The cover page is superb followed by informative articles. The Hindi section is very well thought out

Needless to mention I would like to subscribe to the Journal. Also, let me know if I can be of any help to you including in contributing articles.

Shekhar Bhandari

Asst. Vice President
OM Kotak Mahindra Life Insurance
Company Limited

I had an opportunity to go through the IRDA Journal. I would like to compliment you and the members of IRDA for having published such excellent journal.

The articles appearing in the Journal are quite informative. I also like to compliment the author for the article on 'Insurance, for Insurance Customers' as a part of cover story. I wish all the success to the journal too.

L.P.Mehta

Editor
Asia Insurance Post

I am happy to note that the very first issue of the IRDA Journal is of high standard and truly International. The layout is impressive right from cover page till the last page, both in content and presentation. The Editor and the editorial team have done their best to bring out this remarkable issue.

Please include articles on the following topics: marketing of insurance services with emphasis on consumer behavior, advertising, product management, market research, etc.

You could give fundamentals about technical topics for people who are new to insurance.

You may include a section inviting queries from the readers on topics of their interest on insurance and the answers may be arranged through experts in that particular discipline.

G.Venkata Ramana

Assistant Manager
National Insurance Co Ltd
Hyderabad

I happened to see IRDA Journal. A very nice attempt. It gives us vital statistics of all companies.

From the charts given on page 36 it can be ascertained that the ratio of net premium to gross premium in the case of public sector companies is 73.37% and in that of private companies it is 30.64%. It may give an erroneous impression that private companies are sending a lot of reinsurance premium to foreign reinsurance companies whereas actually it may not be so. The reinsurance may be with the GIC.

So, to give the correct impression, net premium to GIC and foreign companies should be shown. It will also help in ascertaining whether companies are using Indian capacity first or not.

Congrats.

Mohinder Jindal

mohinderjindal@hotmail.com

Thanks for sending me a copy of your journal. I am sure it will be keenly watched. The inaugural issue was very good - easy to read and very informative.

I found this to be very useful because, as a journalist, I have been chasing some of these companies for weeks together to get some information out of them.

You have put a lot of information in neat tables - which gives me a very good base to start on.

N. S. Vageesh

Special Correspondent
The Hindu-Business Line

Please accept my congratulations for bringing out an international quality journal. It is very professionally done and quite informative and certainly will be the undisputed leader in the insurance industry. I have gone through the articles which are extremely useful and user-friendly as highlighted in the Journal.

T G Keswani

Secretary, Finance, Banking &
Insurance Committee
PHD Chamber of Commerce and Industry

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I see satisfaction in customers that they have a competitive option. That feeling of comfort is widespread. But I regret that the market has not innovated and responded to their needs. The industry has to see what it can do about unfulfilled desires.

N. Rangachary, Chairman,
Insurance Regulatory and Development Authority

If nobody is opposing pension reforms you have got to get worried.

Manish Sabharwal, Managing Director, India Life Hewitt

Tariff is a barrier to penetration and growth. Restrictive pricing is going to inhibit the work of intermediaries and affect innovation. The industry is pushing products, not solutions.

Fali S. Poncha, Chairman, International Reinsurance and Insurance
Consultancy Services Pvt. Ltd.

There is a large potential market for writing Directors' & Officers' risk. Insurers have not even started to think about it. They have to understand the internal dynamics of a company. They need to build skills to learn how to price the risk.

Omkar Goswami, Chief Economist, CII

The IRDA has built up credibility. I have foreigners coming up and saying we wish we had a regulator like this in our country. Our insurance regulation is of global standards. Sir, the industry is not perfect, you keep telling them. The IRDA is also not perfect, you keep listening.

Tarun Das, Director General,
Confederation of Indian Industry

Giving all types of training to each agent is irrelevant. Companies have to get distributors into the business who are niche players. We need more intensive and less extensive training.

V. Krishnan, Vice President, National Branch and Agency Operations,
Tata AIG General Insurance Company Ltd.

What they said

at the CII's 7th Insurance Summit at Hyderabad in November

Events

January 3 - 5, 2003

Venue: Vigyan Bhavan, New Delhi

The 15th All India Conference of Chartered Accountants conducted by the Institute of Chartered Accountants of India (ICAI). The theme is "Accountancy — Diverse Demands; Disciplined Approach". Technical session IV on January 4 is on the theme: "Taming the Giant — Coming to Grips with the Financial Sector."

January 9 - 11, 2003

Venue: Pragati Maidan, New Delhi

Pravasi Bharatiya Divas, a three day exposition on Non-resident Indians is being organised by FICCI to engage with all NRIs/PIOs to understand their expectations and to propose a policy framework to ensure their sustained and productive interaction with India. Day 2 has a break-out session on "Financial Services — Emerging Global Trends and Learnings for India."

January 10 - 11, 2003

Venue: National Insurance Academy, Pune

Boda-Marsh Seminar on Natural Disasters and Catastrophic Losses will have participants from both domestic and foreign general insurance companies. Experts from Marsh from London and Boda from Singapore and Mumbai will present the programme along with experts in the fields of construction, radar and remote sensing, and earthquake and cyclone experts.

January 16 - 18, 2003

Venue: New Delhi

The International Association of Insurance Supervisors (IAIS) holds its Committee meeting.

January 20 - 21, 2003

Venue: New Delhi

International Tripartite Conference on Insurance Fraud and Anti-Money Laundering under the auspices of the Insurance Fraud Committee of the International Association of Insurance Supervisors (IAIS).

January 22 - 23, 2003

Venue: Singapore

Asia Insurance Review holds Asia's first Conference on Terrorism Risks Theme: "Responsibilities & Liabilities on Insurers — The Brave New Reality."

January 27 to February 7, 2003

Venue: National Insurance Academy, Pune

"Management of Strategic Issues for Senior Executives in Insurance Companies." Nominations will be received upto January 15, 2003. Get more details from the website of NIA www.niapune.com. or email the Programme Co-ordinators Mr. O.P. Dubey and Mrs. Madhumita Sarkhel at omdubey@niapune.com

January 28 - 29, 2003

Venue: Hyderabad

National Workshop on Data Collection and Research in Motor Insurance organised by the Insurance Regulatory and Development Authority (IRDA) and Concert.

February 4

Venue: Kolkata

The Bengal Chamber of Commerce and Industry holds its Annual Seminar on Insurance.

February 18 - 19, 2003

Venue: Singapore

First Asian Conference on Corporate Governance and Directors' & Officers' Liability by Asia Insurance Review. Theme: "Increased Exposures of Directors in A World of Greater Corporate Governance?"

February 25 - 26

Venue: Hyderabad

National workshop on safety of vehicles in India organised by the Insurance Regulatory and Development Authority (IRDA) and Concert.

February 27 - 28, 2003

Venue: Singapore

First Asian Conference on Commutations & Run-Offs by Asia Insurance Review. Theme: "Strategies in Commutations & Run-Offs to Enhance Operational Efficiency."

February 27 - 28, 2003

Venue: Singapore

Asian Conference on Marine Insurance - Hull, Cargo and P&I (in conjunction with Asia Maritime). The theme is "Reviving Profitability in the Marine Market."