IBAI

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EXCLUSIVE

GO CASHLESS

EARNING A POLICYHOLDER'S TRUST IN THE PHYGITAL INSURANCE SPACE

IBROKER

THIS ISSUE

INSURANCE AND DISASTERS

INSURANCE FRAUD DETECTION & PREVENTION

EARNING A POLICYHOLDER'S TRUST IN THE PHYGITAL INSURANCE SPACE

DROP IN PROPERTY AND ENGINEERING PREMIUM AND HOW TO NAVIGATE THROUGH THE STORM

President's Message

A transformational Year !

Dear Members of the Insurance broking Fraternity,

As we embark on the second half of the year, I hope the initial challenges from the first six months have begun to settle. The significant fluctuations in premiums, particularly in commercial lines, have undoubtedly put pressure on our revenues. I trust that you have been developing innovative strategies to navigate this complex landscape and identify your unique niches.

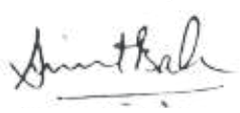
Despite the hurdles, we've seen growth in certain sectors, particularly driven by inflationary trends in health insurance and the demand for new vehicles. The stability in property line premiums, fuelled by increased capex in infrastructure and power, has also contributed positively.

Recently, IBAI representatives met with the new Secretary of the Department of Financial Services, Shri M. Nagaraju, to discuss the current state of the insurance industry. We highlighted how brokers can play a pivotal role not only in premium generation but also in fostering employment growth within the sector.

I am also thrilled to announce our third Chess Tournament on October 19, 2024. This year, we are extending invitations to participants from the entire insurance industry, as well as our counterparts in SAARC countries. The enthusiastic response we've received promises an event that will strengthen our community bonds.

In closing, I encourage all members to continue upholding the highest standards of professionalism and ethics. Together, let's strive to build a more resilient and sustainable insurance brokerage industry in India.

Thank you for your ongoing commitment, Seasons Greetings and best wishes for a successful year ahead.



Sumit Bohra
President IBAI

GO CASHLESS

SEGAR SAMPATHKUMAR

DIRECTOR - HEALTH
GENERAL INSURANCE COUNCIL

India has emerged as a great example for a successful digital payment ecosystem. Billions of cashless transactions are generated month after month in the Unified Payment Platform.

Insurance, like banking, is emerging big in fostering digital enablers.

Insurance is a loss mitigation instrument.Sometimes, the word loss is understood within a narrow framework of monetary loss, without reference to the time value of money. Insurance does make good the loss of the Insured. But if it is mitigated after a considerable delay, the money received loses its sheen and purpose. Claim delayed could at times be as bad as claim denied.

Insurers do realise this imperative. Cashless payments is a reflection of this realisation.Instead of making the customer shell out the cost of loss reparation and then collecting it from the Insurers, the Insurers directly pay the agencies who resolve the adverse effects of the loss, be it repairing the insured vehicle, or treating the insured patient.

The Cashless mode of settlement is a boon to the Insured. She need not undergo the hassle of mobilising the resources for remedying the loss, and then the rigours of seeking reimbursement for the amount expended.The Cashless facility works like magic.The Insurer makes the payment directly to the hospital, and spares the Insured the burden of fronting such unforeseen expense.

Boon as the Cashless Facility is, it is confounding to note that only around two of the three who are hospitalised avail this facility. The one of the three does not avail this facility not because she wants to take the burden of funding the treatment upfront.

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There are several reasons why Cashless Facility is not availed. These include:

1	The Insured is not aware that Cashless Facility is available.
2	In her anxiety, and under the misconception that availing Cashless Facility is cumbersome, the Insured chooses to pay the Hospital directly
3	The Hospital is not enrolled in the Network of the Insurer
4	The Insurer is not willing to offer Cashless Facility to the Hospital
5	The Hospital is not willing to avail Cashless Facility from the Insurance Company.
6	The admissibility of the claim could not be determined before treatment is complete.

Of the six problems listed, the sixth issue, by its very nature, defies a solution. The other five issues could definitely be resolved.

The third issue stands addressed. Cashless Everywhere is an initiative of the Health Insurance industry which seeks to address the third problem. Even if a Hospital were not enrolled in the Insurer's Network, Cashless Facility could be available to the Insured. Cashless Everywhere is thus a remarkable stride on customer empowerment. Under Cashless Everywhere, Hospitals in rural areas, and those not empanelled could still provide Cashless Facility to their Patients.

Cashless For All

The remaining problems too could be resolved if all the stakeholders work together. Bringing awareness of the Facility is the first step that the Insurers and the Intermediaries should take. Interestingly, the Cashless utilisation is lower in Group Policies than in retail Policies. It is hoped that Brokers, who have a significant share of the Group Health Insurance business, would enlighten their customers on the availability of Cashless Facility. The customers should also be guided that Cashless is a pretty simple process which entails no delay.

The Customers should also be sensitised on the need to provide advance intimation, especially for elective surgeries.

The Regulatory advice for Common Panel of Network hospitals will also help expand the network of hospitals and improve cashless utilisation.

Collaboration between Hospitals and Insurance Companies is also enabling wider access to cashless.

With all these measures, it is hoped that the Customer will be spared the burden of fronting an unforeseen healthcare expense.

SARBVIR SINGH
CEO
Policybazaar

EARNING A POLICYHOLDER'S TRUST

IN THE PHYGITAL INSURANCE SPACE

In the insurance industry, success metrics are merely indicative. They indicate how one has fared in earning their customers' trust. Our country has a growing middle class that needs adequate financial protection against death, disease, and/ or disability. Historically, a trust deficit has hampered the adoption of insurance among this demographic. Factors such as limited financial awareness and an agent-centric industry setup played pivotal roles in perpetuating this skepticism. However, with the advent of technology and the rise of digital insurance platforms, the paradigm is shifting towards a more consumer-centric approach, blending physical and digital interactions seamlessly — termed as the "phygital" approach.

BRIDGING THE GAP: TECHNOLOGY AS A CATALYST

The integration of technology, particularly through artificial intelligence and voice analytics, has revolutionized how insurers engage with their customers. Insights gleaned from these technologies enable greater empathy and accuracy in customer relations, fostering trust by demonstrating a deeper understanding of individual needs. This shift towards customer-centricity is further bolstered by regulatory support, with bodies like IRDAI (Insurance Regulatory and Development Authority of India) championing the role of insurtech in transforming the industry. This along with thoughtful models like PoSP has given impetus to the phygital approach.

EMPOWERING THE CONSUMER: RISE OF DIGITAL MARKETPLACES

The rise of digital marketplaces has democratized access to insurance products, particularly appealing to a growing middle class eager for financial protection. Traditionally, insurance in India was agent-reliant, but the emergence of DIY trends indicates a fundamental shift in consumer behavior. Digital platforms now offer tools like Human Life Value calculators, empowering consumers to make informed decisions about their insurance needs independently. Simplified policy information and initiatives such as telemedicine for NRIs further enhance transparency and accessibility, placing the consumer at the heart of the insurance experience.

Furthermore, advancements in artificial intelligence (AI) and machine learning are enhancing various aspects of the insurance experience.

AI-driven underwriting processes ensure more accurate risk assessments, while AI-based morbidity predictions help in customizing health insurance plans. Fraud detection systems and digital inspection tools bolster trust by safeguarding against potential misuse.

The integration of these technologies into digital platforms facilitates not only more personalized and efficient services but also a more secure and transparent claims process. By leveraging and other advanced tools, insurers can offer quicker claims assistance and settlements, which is crucial for maintaining customer confidence.

In parallel, the importance of maintaining a balance with physical interactions cannot be overstated. The phygital approach—blending physical and digital interactions—ensures that customers in tier 2 and 3 cities, who may prefer face-to-face engagements, are not left behind. This approach enhances accessibility and addresses the psychological comfort that traditional interactions provide.

By combining the strengths of digital innovations with the reassurance of physical interactions, the insurance industry can create a more inclusive and trustworthy environment for all consumers.

INCLUSIVITY AND PERSONALIZATION: ADDRESSING DIVERSE NEEDS

The insurance industry is increasingly recognizing the diverse needs of its customer base, particularly women who historically have been overlooked as primary decision-makers. Independent term insurance policies tailored for women, along with broader health insurance coverage encompassing mental health and maternity benefits, reflect a proactive approach towards inclusivity.

Digital platforms have played a crucial role in raising awareness about these tailored products, empowering women to actively participate in financial planning and protection.

PHYGITAL EXPANSION: BEYOND METROS TO TIER 2 AND 3 CITIES

As India's economic landscape evolves, so does the imperative for broader insurance penetration beyond metropolitan areas. The concept of "phygital" insurance — offering the efficiency of digital transactions coupled with the reassurance of physical interaction — has been instrumental in reaching tier 2 and 3 cities. This approach not only enhances accessibility but also addresses the psychological comfort that traditional face-to-face interactions provide. The success of this model is evident in the shift of business dynamics, with a significant portion of transactions now originating from non-metro regions.

Earning a policyholder's trust in the phygital insurance space hinges on leveraging technology to enhance customer engagement, ensuring seamless claims experiences, and embracing inclusivity through personalized products. The journey towards building this faith is multifaceted, encompassing regulatory support, technological innovation, and a customer-first approach that empowers individuals across diverse demographics. As India progresses towards greater financial inclusion and consumer empowerment, the role of digital platforms in reshaping the insurance landscape cannot be overstated. By prioritizing transparency, accessibility, and customer-centricity, insurers can not only earn but also sustain the confidence of policyholders in this dynamic phygital era.

Insurance solutions for the deteriorating disaster or catastrophe landscape of the world owing to climate change and other factors are now gaining ground. There is little scope for ex-post (after the event) assistance for those dispossessed and impoverished by catastrophes. Disaster occurrences are mega events which are usually termed as 'Act of God'. The term 'Act of God' predisposes a mindset of resignation and inevitability. Disasters were not insured commonly earlier as insurers gave covers on very selective and restrictive insurance clientele. Moreover, from a technical view of insurance concepts, catastrophes are considered uninsurable as disaster risks have high correlations and extraordinary destructive potential. Now mindsets are changing as governments and regulators push for 'rural and social' insurance, micro-insurance, crop-insurance and so on. Insurers are also conscious of the public good that insurance can bring and there is a consensus that catastrophe risks are to be insured.

Disaster relief steps are essential whether ex-post (after the disaster) or ex-ante (before the disaster). There are diametrically opposite distinctions between ex-post and ex-ante approaches to help the victims and potential victims of disasters. In the ex-post scenario, victims of disaster are helpless and look to families, communities and governments for help. International aid may pour in and many social organisations also pitch in. But all this is mostly short-term 'Band-Aid' like help and soon memories fade and the distressed are often left to fend for themselves as another disaster comes up elsewhere or disaster assistance fatigue sets in. The beneficiaries of such aid are seen as supplicants and their dignity and wellbeing get denigrated in many ways.

Sustainability against disaster threats therefore calls for ex-ante approaches. Disasters normally happen in any region usually after a gap of many years. They take place in a fortuitous and sudden manner. This makes it ideal for pooling and insurance, though they are catastrophic and can exhaust insurance capacity. Losses are payable if the pool can build up a diversified fund across geographies and time. This makes insurance a very natural answer to disasters. There are many positives that insurance can offer to make disasters manageable for those facing them from an indemnification point of view.

These are:

- Insurance is a risk management tool and insurers can help customers, the community and the government to establish risk reduction approaches for managing better disasters such as floods and storms.
- Insurers can offer affordable premium rates if everyone can be made to insurer against disasters.
- Insurance pools can be set up where disasters are not easily insurable and governments can look at indemnifying only losses that are in excess of the pool capacity.
- Insurers across the world could join together to strengthen capacity and open up more options to support indemnification of disaster losses.
- Insurance policies are contracts and hence the policyholder gets legal rights for compensation, which does not happen in case of aid and assistance.
- Insurers and government organisations could organise quickly assessments of loss at micro-levels to help to finalise settlements. Governments, to facilitate quick insurance-based reconstruction can regulate the rent-seeking behaviour of the various agencies that repair and reinstate damaged items.
- Immediate liquidity is available with insurance covers as both they and the reinsurers etc. will bring in funds
- The indemnification can help speedy recovery at the point of loss for the multitude of those who have lost in their individual manner, because the indemnity is based on time tested insurance practices.
- The money saved by governments can be used to restore the common infrastructure and take further action to minimise future losses.
- Insurance has the capability to offer holistic solutions to reduce human suffering, economic losses, as also fiscal pressures. It will help to kick-start economic recovery.

A well-designed insurance solution reduces disaster consequences in two ways: (1) It provides early liquidity and thereby prevents long-term loss of livelihood and lives; and (2) It prices risk on actuarial basis and can incentivise pre-disaster risk reducing behavior. In countries where disaster construction standards are set home owners who choose to disaster-proof their assets pay a lower insurance premium, because insurance promotes investing in risk reduction. If insurance is not designed to motivate risk minimisation, investments in loss prevention may not happen and can even encourage negligent behaviour (moral hazard).

Therefore, from a primarily reactive or coping approach traditionally resorted to when dealing with natural and other disasters, insurance can introduce useful catastrophe risk management frameworks to quantify, analyze and manage potential losses. All stakeholders would generate inputs that get populations ready to face traditional disasters and avoid deaths and injuries and in time minimise property losses. Therefore, insurance inclusion should be given high priority.

A systematic enrolment of everyone at risk is to be done to ensure that all of them are satisfactorily insured. There has to be incentives and mandated requirements to ensure insurance habits among the better off households. Catastrophe insurance may have to be made compulsory when financing assets. It can also be tied to property or land tax or their registration systems. Such steps should compel all those above poverty line to take insurance. Governments who bear the brunt of post-disaster aid should make it clear to such households that they will not be eligible for government reconstruction funding or aid.

The future of disasters indicates that loss amounts will go up and move across many non-correlating areas. In the earlier Chennai floods, the airport was immobilized and many aircrafts were damaged. This has added another frightening dimension for reinsurers about new correlations that suddenly creep up when disasters strike. As the wealth level of the population goes up, so also asset values will go up and premium levels may have to go up to gear up for larger and wider losses and indemnity pay-outs.

Catastrophe risks traditionally did not allow insurability owing to breach of one of the fundamental conditions of insurability. This would call for insurers to use sophisticated modeling techniques to try to estimate catastrophe risk and how to diversify the risk exposure therefrom. Efficient risk diversifications are possible through many methods such as:

- Reducing insurer's concentration of exposures, by geographic and other diversifications;
- Designing proper pricing, terms and conditions of the policy:
- Encouraging risk reduction and mitigation by those getting insured;
- Obtaining reinsurance that diversifies risks across global markets;
- Utilizing catastrophe-hedging financial instruments from the capital markets;
- Holding more capital as may be directed by the Regulator
- Establishing catastrophe pools

Insurance mechanisms have a promising role in facing disasters at the economy level. The potential benefits of wholesale disaster insurance include providing security against the widespread loss of assets, livelihoods, and even lives in the post-disaster period.

Customer Protection for Disaster Insurance

Regulations would be required to ensure that customers/policyholders are duly protected while insuring for disaster protection.

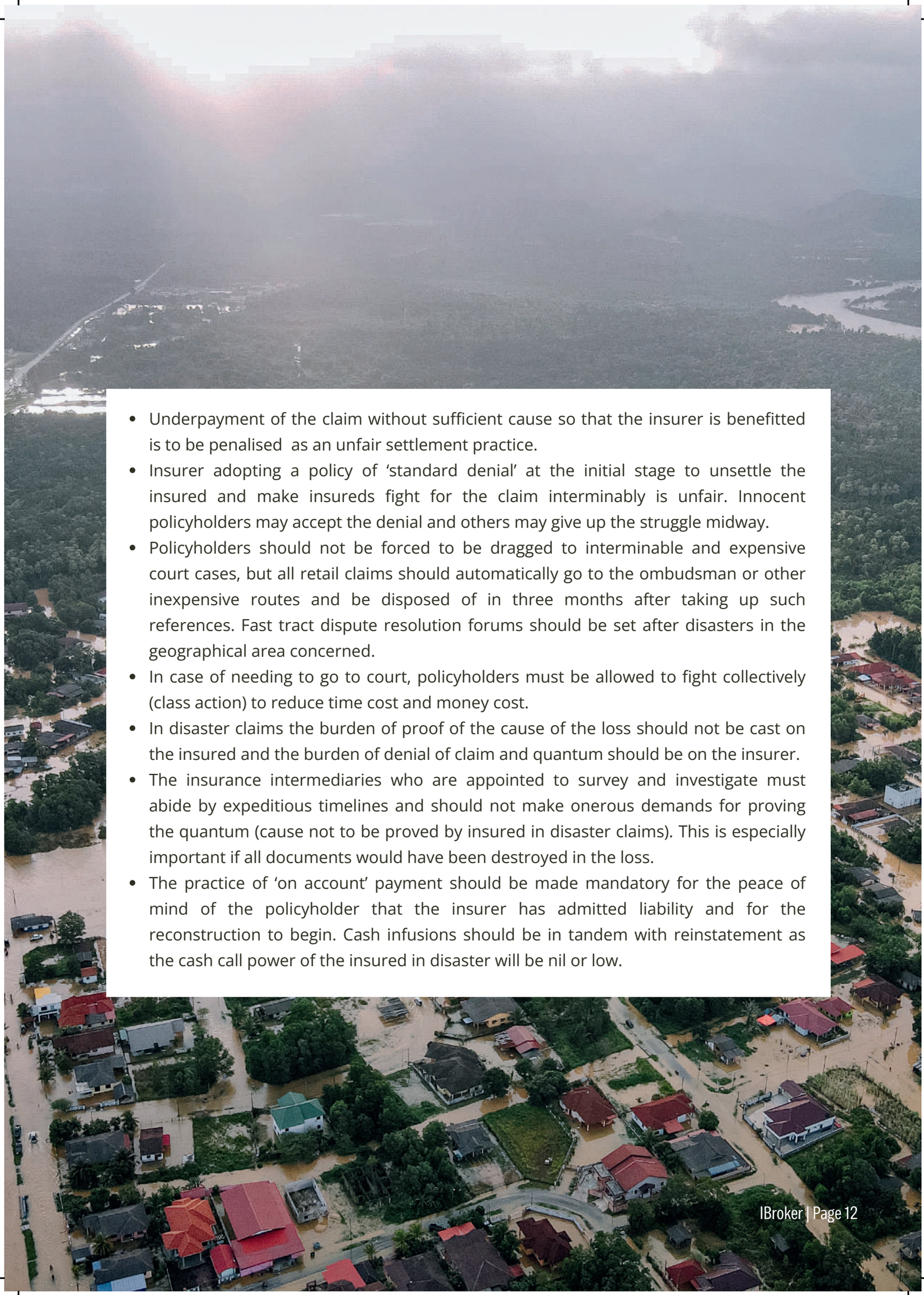
Coverage Issues

- Insurers may deny coverage and hence the standards for covering the risk and the rates and terms of coverage etc. need to be spelt out by insurers in the public domain and coverage must be facilitated for everyone.
- 1.Standards for the width and depth of coverage, conditions and exclusions applicable should be made to ensure that the policyholder is indemnified as desired by public policy.
- Renewals cannot be refused except on grounds specified by regulation and renewal facilitation must be made online and offline.
- Guidance for change in the value of the assets and other requirements for ensuring that the policy is taken in the right manner must be communicated to the insured.
- The mode of indemnity for retail customers must necessarily be on reinstatement value as cash value would be inadequate for getting the property restored as before the loss.
- Where reinstatement may not be possible in cases such as crumbling buildings, lesser methods of compensation of property can be mandated.

Claim Settlement Issues

Unfair claim settlement practices are being decried across the world and punitive actions are now being increasingly considered especially in cases of disaster losses. What constitutes fair settlement, the violation of which is treated as unfair settlement is now an expanding field and includes:

- The insurer has to provide all benefits and coverage as provided in the policy and should not hide or deny the same because the insured is ignorant of the benefit or did not claim in the manner as required by the insurance company.
- Delay in claim assessment to take advantage of the claimant and appointment of multiple surveyors and investigators and asking for many and possibly unnecessary documents is unfair.



- Underpayment of the claim without sufficient cause so that the insurer is benefitted is to be penalised as an unfair settlement practice.
- Insurer adopting a policy of 'standard denial' at the initial stage to unsettle the insured and make insureds fight for the claim interminably is unfair. Innocent policyholders may accept the denial and others may give up the struggle midway.
- Policyholders should not be forced to be dragged to interminable and expensive court cases, but all retail claims should automatically go to the ombudsman or other inexpensive routes and be disposed of in three months after taking up such references. Fast tract dispute resolution forums should be set after disasters in the geographical area concerned.
- In case of needing to go to court, policyholders must be allowed to fight collectively (class action) to reduce time cost and money cost.
- In disaster claims the burden of proof of the cause of the loss should not be cast on the insured and the burden of denial of claim and quantum should be on the insurer.
- The insurance intermediaries who are appointed to survey and investigate must abide by expeditious timelines and should not make onerous demands for proving the quantum (cause not to be proved by insured in disaster claims). This is especially important if all documents would have been destroyed in the loss.
- The practice of 'on account' payment should be made mandatory for the peace of mind of the policyholder that the insurer has admitted liability and for the reconstruction to begin. Cash infusions should be in tandem with reinstatement as the cash call power of the insured in disaster will be nil or low.

BASICS OF REINSURANCE

Insurers issue policies against the promise of paying claims when covered losses occur. If at the time of claim, which usually has a lag, the insurer has no solvency, the claim amount will be lost to the customer or underpaid. So, the long-term financial solvency of the insurer is of utmost importance. Reinsurance is a critical component in ensuring solvency for insurers as the potential of large catastrophic losses makes the position of insurers risky unless there is a reinsurance back-up.

Reinsurance is insurance for insurance companies. It is a way of transferring some of the financial risk insurance companies assume in insuring various risks to a higher order or level insurance company, the reinsurer. By law, an insurer must have sufficient capital to ensure it will be able to pay all potential future claims related to the policies it issued. This requirement protects consumers but limits the amount of business an insurer can write or assume. However, if the insurer can reduce its responsibility, or liability, for these claims by transferring a part of the liability to another insurer, it can lower the amount of capital it must maintain to satisfy regulators that it is in good financial health and will be able to pay the claims of its policyholders. Capital freed up in this way can support more or larger insurance policies. The company that issues the policy is known as the primary insurer. The company that assumes liability from the primary insurer is known as the reinsurer. Primary companies are said to “cede” business to a reinsurer.

In reinsurance, an insurer transfers part of the premium collected from reinsurable large risks to the reinsurer. In return the reinsurer accepts by contract, a part of the risk assumed by the insurer. There are various kinds of reinsurances. In proportionate reinsurance, premiums and claims are shared between the insurer and reinsurer in the proportion stipulated in the contractual agreement. In addition, the reinsurer pays ceding commission to the insurer. In non-proportional insurance, the reinsurer assumes only the losses that exceed a certain level, called the retention or priority. In calculating the premium for the risk transferred, the reinsurer looks at the loss experience during the previous years and the expected future losses according to the type of risk covered.

An insurer can easily diversify their risk when losses of individual policyholders are statistically independent. An example of such risk is motor vehicle collision. In such cases the expected losses from a large pool of such vehicles covered are highly predictable, and the loss per claim is usually moderate. In such cases the insurer can cover large number of policyholders without having high levels of capital.

This statistical independence is broken, when there are large mega-catastrophic losses. A single event can cause losses to many policyholders at the same time. However, the risk of a catastrophe in Bihar or UP is somewhat independent from a catastrophe in a southern state. So also, a catastrophe in another country is independent from the one in India. This provides for motivation for organising a global reinsurance market.

This global diversification by reinsurers also helps them to keep their capital levels lower than, if there was a concentrated approach. Reinsurance thus ideally needs to have global reach as this allows diversification of risks across geographies. Reinsurance purchase by insurers is part of their capital structure decision, because if there is enough reinsurance, the level of capital required is less. Reinsurance, thus pays the role of substitute capital

Reinsurers have the ability to raise capital quickly, even when large disasters reduce their solvency. This allows for alleviating the underwriting cycle of soft and hard markets, even for the primary insurers. The quality of reinsurance purchased is a feature of the insurance sold to their customers by direct insurers. It is a fact that smaller insurers need much more reinsurance than larger insurers.

Types of Reinsurance

- Facultative Reinsurance

  This type of reinsurance protects an insurer for an individual or a specified risk or contract. If several risks or contracts need reinsurance, they are renegotiated separately. The reinsurer holds all rights for accepting or denying a facultative reinsurance proposal. Such proposals are individually underwritten by the reinsurer.

- Treaty Reinsurance

  A reinsurance treaty is for a set period rather than on a per-risk or contract basis. The reinsurer covers all or part of the risks that the insurer may write.

Under proportional reinsurance, the reinsurer receives a pre-agreed share of all policy premiums received by the insurer. For a claim, the reinsurer bears a portion of the losses based on a pre-negotiated percentage. The reinsurer also reimburses the insurer for processing, business acquisition, and writing costs.

With non-proportional reinsurance, the reinsurer is liable if the insurer's losses exceed a specified amount, known as the priority or retention limit. In the case of non-proportional reinsurance, the reinsurer does not have a proportional share in the insurer's premiums and losses. The priority or retention limit is based either on one type of risk or an entire risk category.

Excess-of-loss reinsurance is a type of non-proportional coverage in which the reinsurer covers the losses exceeding the insurer's retained limit or surplus share treaty amount. This contract is typically applied to catastrophic events and covers the insurer either on a per-occurrence basis or for the cumulative losses within a set period.
Under risk-attaching reinsurance, all claims established during the effective period are covered, regardless of whether the losses occurred outside the coverage period. No coverage is provided for claims originating outside the coverage period, even if the losses occurred while the contract was in effect.

In brief, reinsurance is insuring insurers. Only by reinsuring can insurers, known as primary insurers, be able to offer cover against their large or non-diversified risks. This allows the insurance market rates also to be more affordable as reinsurance allows more affordability and management of risks. By reinsurance everyone's risks are reduced and the primary insurers are freed of more capital requirements and thus they can accept more business and this further helps insurance growth and economic growth.
Thus, by reinsurance primary insurers protect their balance sheet, reduce the volatility of their earnings and there is more efficient use of capital and reduction of premium costs. By spreading risks around the world reinsurers avoid over-exposure and are a stabilising factor in the local (country) markets. Without reinsurance it would be difficult to insure extremely large projects, aviation or marine hull risks.

HOW UNDERWRITERS SERVE THE INTERESTS OF ALL STAKEHOLDERS?

Underwriting is the quintessential insurance skill. It can be termed as an insurer's core competence. In a world that is increasingly governed by uncertainties and vulnerabilities, The underwriting skills of the insurer has to be forward looking, dynamic and innovative. Everyone, therefore, agrees that underwriting has to move from being a rule-based task to a risk-based skill.

The skills of underwriting are compatible with all the known characteristics of the industry. Thus, insurance is commonly perceived as sold and not bought, and therefore the push factor predominates, especially in new business procurement. Typically, an insurer will look with wariness at a new prospect voluntarily and energetically trying to buy a cover direct from an insurer. It is well known that such pull factor gets clearly seen at a time which insurers would suspect as an insured's 'apprehensive quest', meaning the insured expects something to happen.

In the classic case General Assurance Society Ltd vs Chandumull Jain and Anr, 1966 AIR 1644, the Supreme Court agreed that the insurer has a right to cancel the cover note, after the insurer by an inspection found that a flood was likely to take place, at the location the insured's risk was located.

This is where the traditional values of intermediation and the push factor can be invaluable to a seasoned underwriter, because good intermediaries are termed to be 'first line underwriters'. They not only ensure that moral hazard is reduced, they also take due care that a more authentic filling of the proposal form takes place. The intermediary helps to clarify grey areas, inspect the risk if required and so on. Therefore, the so called 'dissonance and discordance' as claimed between underwriting and marketing, actually can be made into a powerful synergy, for the healthy higher order growth of the industry.

UNDERWRITING AS A MARKETING TOOL

Sound underwriting is also good marketing. Marketing is ultimately about attracting the customer by creating and offering value. Underwriting typically endeavours to fashion offered risks into better – and therefore more desirable and insurable risks. It assists the insured to grasp the potential threats contained in the risk, minimise hazards and improve safety features so as to reduce downtime and costs.

Therefore, a good underwriter turns out to be one who is close to the customer and a top marketer for the insurer by attracting clients through capability in shaping risks and ensuring betterment in a transparent and intelligible manner. Ideal underwriting tends not only to improve the insurability of the risk and reduce its risk intensity, but also endeavours to improve the risk inducing behaviour of the insured.

Good underwriting can thus free the mind of an entrepreneur or organisation to focus on its competence in the area of business risks and transfer non-business risks to the insurer. An experienced underwriter will slowly begin to 'own' customers merely by being true to competencies in underwriting.

A CONSUMER-FRIENDLY ACTIVITY

Underwriting is often pictured as an activity that merely helps insurers only (the no syndrome), and therefore acts against the insured. Nothing can be further from the truth. Good underwriting in its essence offers true protection, and helps the insured in all aspects of risk management. It helps to determine the level of self-insurance, the implementation of loss minimising steps, the amount of risk transfer, and the levels of sum insured, deductibles, warranties and conditions that are optimal for both parties and so on. Underwriters, thus, will increasingly be valued as specialists in risk recognition, risk assessment, risk management, risk transfer, risk acceptance and risk retention and prove a boon to a society that looks to a future which will be secured through the mastery of risk.

Good underwriting thus becomes a tool for social good, as well. It differentiates between good risks and bad risks and advises risk betterment, enforces warranties, seeks compliance of laws, regulations and various safety practices, and finally prices risk in such a manner that risk improvement is made an underlying necessity for day-to-day activities.

An underwriter's nod that insurance can be granted often acts as a good certificate to bankers, auditors, other stakeholders and the public. Thus, good underwriting needs all encouragement, as this alone will bring in awareness of risks and endear the public to insurance buying.

Deepening and widening insurance protection in all sectors of the economy is considered essential for development and social engineering. This results in risk contraction in the lives of people and organisations and supports progress and prosperity. Good underwriting, and its underlying prudence, enhance safety and security and raise the confidence level of all the stakeholders in the society.

A CHALLENGING TASK

From an insurer's point of view, underwriting is important because of the complexity involved in taming risks. The full dimensions of risks are hard to fathom and keep changing as technology and development move forward.

The separation of risks from the green insurable to the red uninsurable, and making the right kind of insurance to satisfy the needs and wants of insureds, and thus securing their future through risk containment are great services for the spread of insurance. At the same time good underwriters protect the bottom line of the insurer, because insurer solvency is of utmost necessity for the survival and success on the industry and assures the insured of the claim paying capacity of the insurer.

THE ESSENCE OF THE ART

The essence of underwriting is risk recognition, assessment, shaping, containing and pricing. It includes the ability to measure the dimensions of potential loss exposure as well as to set and obtain an adequate return for accepting the risk transfer. The underwriting process thus has many aspects:

Information capture and management

Data, information, knowledge and experience are the lifeblood of good underwriting practices. Underwriting is moving away from anecdotal and unverified conclusions to one led by clear data collected over time and geographies, and models and structures which can be created to sustain clear underwriting strategies.

Selection

Grading of risks plays a role that is important in terms of equity for the customer and survival for the insurer. Grading can be on various parameters such as frequency /severity, desirable/undesirable, long term/ short term, concentrated/ dispersed, etc. Risk betterment, pricing, warranties and conditions, limitations on the cover offered indicate the choices before the insurer while considering a risk. It is also possible that a risk is not insurable and the reasons need to be spelt out.

Pricing

Pricing is the most important factor of underwriting, as markets are dynamic and customers are dictated by the costs they face in transferring risks. Underwriters would often face the paradox that they are

required to offer more and more benefits at softening rates and terms. Deficiency in pricing, at the same time, is fraught with severe consequences.

However, underwriters have many weapons in their armoury which can include well known techniques, such as application of deductibles, imposition of warranties, limiting of covers, deletion of perils and ceiling on claims etc., to ensure that prices and risks accepted match in a way that the insurer gets a return on the capital deployed.

However, underwriters have many weapons in their armoury which can include well known techniques, such as application of deductibles, imposition of warranties, limiting of covers, deletion of perils and ceiling on claims etc., to ensure that prices and risks accepted match in a way that the insurer gets a return on the capital deployed.

THE INDUSTRY NEEDS THIS NEW UNDERWRITER

The real underwriter will be focused on the dynamics of risk and will not be trapped by the rigidities of outdated procedures and rules. Such an underwriter will adapt to global best practices, be updated on facts and analyses, avidly build-up hands on experience and keep expanding in the knowledge areas concerned.

Pricing challenges in a soft market is going to set apart the men from the boys. Pricing discipline is the most essential facet of the skill and requires excellence in examining the boundaries of various possibilities on the one side to satisfy customer expectations dictated by market conditions, and at the same time re-examine the orthodoxies of underwriting to arrive at terms that will still get a return on equity as desired. It also means having real courage to vacate segments that are hopelessly under-priced till pricing conditions return to normal. Insureds will recognise this and will not mind paying a little more premium to ensure best underwriting skills and a solvent insurer.

FOR THE BENEFIT OF INSUREDS

CONSUMER DISPUTES REDRESSAL FORUMS

The Consumer Protection Act, 2019 is a benevolent social legislation to enable ordinary consumers to secure less expensive and often speedy redressal of their grievances. To provide inexpensive, speedy and summary redressal of consumer disputes, quasi-judicial bodies have been set up in each District and State and at the National level, called the District Consumer Disputes Redressal Commissions, the State Consumer Disputes Redressal Commissions and the National Consumer Disputes Redressal Commission respectively. At present, there are 678 District Commissions and 35 State Commissions with the National Consumer Disputes Redressal Commission (NCDRC) at the apex level.

The provisions of this Act cover 'goods' as well as 'services'. The goods are those which are manufactured or produced and sold to consumers through wholesalers and retailers. The services are in the nature of transport, telephone, electricity, housing, banking, insurance, medical treatment, etc.

A written complaint, can be filed before the District Consumer Commission for pecuniary value of upto Rupees 50 Lakh; State Commission for the value from Rupees 50 Lakh One upto Rupees 2 crores and the National Commission for value above Rupees Two Crore, in respect of defects in goods and deficiency in service.

However, no complaint can be filed for alleged deficiency in any service that is rendered free of charge or under a contract of personal service.

The remedy under the Consumer Protection Act is an alternative in addition to that already available to the aggrieved persons/consumers by way of civil suit. In the complaint/appeal /petition submitted under the Act, a consumer is not required to pay any court fees but only a nominal fee. Consumer Commission proceedings are summary in nature. The endeavour is made to grant relief to the aggrieved consumer as quickly as in the quickest possible time, keeping in mind the provisions of the Act which lay down time schedule for disposal of cases.

If a consumer is not satisfied by the decision of a District Commission, he can appeal to the State Commission. Against the order of the State Commission a consumer can come to the National Commission.

Functioning of District Commission, State Commission and National Commission is consumer friendly; thus, a consumer can file a complaint and also address arguments in person. In genuine cases where the complainant/ appellant/ petitioner before the National Commission is unable to engage the services of an advocate, legal aid is provided by the Commission free of charge.

FAQ's

WHO IS A CONSUMER?

A Consumer is a person who purchases a product or avails a service for a consideration, either for his personal use or to earn his livelihood by means of self employment. It also includes a beneficiary of such goods/services when such use is made with the approval of such person.

WHO IS NOT A CONSUMER?

A person is not a consumer if he/she: purchases any goods or avails any service free of charge; purchases a good or hires a service for commercial purpose; or avails any service under contract of service

WHAT ARE GOODS?

"Goods" means every kind of movable property other than actionable claims and money, and includes stock and shares, growing crops, grass and things attached to or forming part of the land, which are agreed to be severed before sale or under the contract of the sale.

WHAT IS A DEFECT?

"Defect" means any fault, imperfection or shortcoming in the quality, quantity, potency, purity or standard which is required to be maintained by or under any law for time being in force or under any contract, express or implied, or as is claimed by the trader in any manner whatsoever in relation to any goods.

WHAT ARE SERVICES?

"Service" means service of any description which is made available to potential users and include, but not limited to, the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information, but does not include the rendering of any service free of charge or under a contract of personal services.

WHAT IS DEFICIENCY IN SERVICE?

"Deficiency" means any fault, imperfection shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.

WHAT IS UNFAIR TRADE PRACTICE?

An "unfair trade practice" means a trade practice, which, for the purpose of promoting any sale, use or supply of any goods or services, adopts unfair method, or unfair or deceptive practice.

HOW TO FILE A COMPLAINT?
The complaint can be filed on a plain paper.
Email marketing, content marketing, events
It should contain the details of the complainant and the opposite party.
Complaint can be registered, in person, by the complainant or through his authorized agent or by post addressed to the Redressal Agency.
It is not compulsory to engage a lawyer to file a case.
The fees charged are very nominal according to the value of the claim.

WHAT IS THE PROCEDURE TO FILE COMPLAINT IN CONSUMER FORA?

A complaint when made in District Forum or State Commission shall be filed in three sets and where it is filed in the National Commission, it shall be filed in four sets with additional sets equal to the number of opposite party(s).

Every complaint shall clearly contain particulars of dispute and the relief claimed and shall also be accompanied by copies of such documents as are necessary to prove the claim made in the complaint.

A Consumer can argue his own case or can be represented through authorized person or agency. Is there a need to engage a lawyer for filing a complaint in the fora?
There is no need to engage a lawyer or any other pleader and consumer can himself or through his representative file and represent his complaint.

WHAT ARE THE PARTICULARS TO BE FURNISHED ALONG WITH THE COMPLAINT?

The complaint should contain the following particulars

Name and complete address of the complainant	Details of complaint, whether it is against Unfair Trade Practice / supply of defective goods / deficiency in service provided / collection of excess price, should explicitly be mentioned in the complaint petition
Name and complete address of the opposite party/parties	Bills / receipts and copies of connected correspondence, if any.
Date of purchase of goods or services availed	Relief sought for under this Act.
Amount paid for the above purpose	Complaint should be signed by the complainant or his authorised agent.
Particulars of goods purchased with numbers or details of services availed.	

WHAT IS THE TIME LIMIT FOR FILING A COMPLAINT?

A complaint has to be filed within two years from the date on which the cause of action/ deficiency in service/defect in goods arises. However, a complaint may also be filed after two years, if the complainant satisfies the District Forum that he/she has sufficient reasons for not filing the complaint within such period.

WHAT IS THE PROVISION FOR APPEAL?

- Aggrieved by the Order issued by the District Forum, appeal petition may be filed before the State Commission within 30 days from the date of receipt of Order.
- Aggrieved by the Order issued by the State Commission, appeal petition may be filed before the National Commission within 30 days from the date of receipt of Order.
- Aggrieved by the Order issued by the National Commission, appeal petition may be filed before the Supreme Court of India within 30 days from the date of receipt of Orders.

WEBSITE OF THE DEPARTMENT

http://consumeraffairs.nic.in

WEBSITE OF THE NCDRC

http://ncdrc.nic.in/

STATE COMMISSION DETAILS

http://ncdrc.nic.in/statelist.html

DISTRICT FORUMS DETAILS

http://ncdrc.nic.in/districtlist.html

Insurance Fraud Detection &Prevention

DEFINITION OF FRAUD BY COURT

In the case Danepoint Ltd v Underwriting Insurance Ltd [2005] EWHC 2318 (TCC), the court reiterated the definition earlier given by Justice Mance: “The definition of fraud in circumstances such as these is that of Mance L.J. (as he then was) in The Aegeon [2003] QB 556. At para.30 he said: "A fraudulent claim exists where the insured claims knowing that he has suffered no loss or only a lesser loss than that which he claims (or is reckless as to whether this is the case). A fraudulent device is used if the insured believes that he has suffered the loss claimed but seeks to improve or embellish the facts surrounding the claim by some lie."

Complete fraud prevention may be an impossible task. US courts probably understood this. In the case Roberson v. Williams, 240 N.C. 696 (N.C. 1954), the Supreme Court of North Carolina stated:

"Fraud has no all-embracing definition. Because of the multifarious means by which human ingenuity is able to devise means to gain advantages by false suggestions and concealment of the truth, and in order that each case may be determined on its own facts, it has been wisely stated `that fraud is better left undefined,' lest, as Lord Hardwicke put it, `the craft of men should find a way of committing fraud which might escape a rule or definition.' Furst v. Merritt, 190 N.C. 397 (p. 404), 130 S.E. 40. However, in general terms fraud may be said to embrace `all acts, omissions, and concealments involving a breach of legal or equitable duty and resulting in damage to another, or the taking of undue or unconscientious advantage of another.'"

FRAUD PREVENTION ISSUES – EXAGGERATION IN ESTIMATES ETC CAN BE FOR NEGOTIATION OR FOR FRAUD?

In claims insureds are asked to give estimates of loss. Usually, the same can be exaggerated

or wildly exaggerated. Hence courts stated that latitude has to be shown by insurers when alleging fraud by the insured. When discussing the principles relating to fraud the UK court in the case Tonkin & Anor v UK Insurance Ltd. [2006] EWHC 1120 (TCC) in para 179, stated that “Are there any other relevant principles which govern allegations of fraud in insurance cases? It is fair to say that the authorities demonstrate a degree of latitude allowed by the courts in relation to allegations of fraud in insurance cases. Plainly that latitude did not extend to the 12% of the whole claim identified in Galloway, or the 11% in the case of Direct Line v Khan [2001] EWCA Civ 1794 which followed it. On the other hand, Thomas J in Nsubuga at page 686 expressed the view that it: "... would not generally in those circumstances be right to conclude readily that someone had behaved fraudulently merely because he put forward an amount greater than that which he reasonably believed he would recover".

In similar vein, in Orakpo v Barclays Insurance Services [1995] LRLR 443, Lord Hoffmann expressed the view that: "In cases where nothing is misrepresented or concealed and the loss adjuster is in as good a position to form a view of the validity of the claims of the insured, there would be a legitimate reason that the insured was merely putting forward a starting figure for negotiation."

WITNESS STATEMENTS

In Savash v CIS General Insurance Ltd [2014] EWHC 375 (TCC), the court stated in para 19. “Some helpful guidance was provided by Lord Justice Robert Goff as he then was in The Ocean Frost [1985] 1 Lloyd's Rep. 1 at Page 57: "Speaking from my own experience, I have found it essential in cases of fraud, when considering the credibility of witnesses, always to test their veracity by reference to the objective facts proved independently of their testimony, in particular by reference to the documents in the case, and also to pay particular regard to their motives and to the overall probabilities. It is frequently very difficult to tell whether a witness is telling the truth or not; and where there is a conflict of evidence such as there was in the present case, reference to the objective facts and documents, to the witnesses' motives, and to the overall probabilities, can be of very great assistance to a Judge in ascertaining the truth."

Since 1985, practice has moved on, for instance in relation to the requirement for Statements of Truth not only at the foot of pleadings but also at the end of witness statements which are now exchanged as a matter of course. Where there are material departures by a party from his or her pleadings or exchanged witness statements or other recorded statements made contemporaneously with the events to which the evidence relates, that can be a strong, sometimes very strong, pointer as to whether there is or is not merely an honest mistake being made.”

Some indicators leading to repudiation when fraud is suspected

Courts are clear that all facts and circumstances should be examined and based on the balance of probabilities only, a fraud decision should move forward.

In the NCDRC in the case Surinder Pal Singh vs United India Insurance Company (2017), the court made very cogent examination relating to fraud in the case of a claim:

1	No expert evidence has been produced by the complainant to prove the fact of there being a short circuit which caused the fire resulting into the damage/ loss.
2	The complainant has not called the fire brigade to extinguish the fire and he has admitted that the fire was extinguished by the neighbours.
3	Complainant has not produced even an iota of evidence to establish that he has sustained a loss to the tune of Rs.7.00 lakh in this fire. The loss assessed by the surveyor comes to Rs.62,907/-.
4	Complainant has also not been found to have come to the forum with clean hands as it stands established in the report of the surveyor that he has tried to conceal the factum of keeping certain cloths in the adjoining shop. In our considered opinion complainant was supposed to narrate this fact to the investigator and surveyor.
5	Complainant has disposed of the salvage without the prior permission of the opposite party and this act of the complainant amounts to breach and violation of the terms of the insurance policy.
6	Complainant has failed to adduce any documentary evidence or stock register or any other records to evidence the facts that cloths worth Rs.7.00 lakh were lying in his shop and also the evidence to establish that the entire stock was completely burnt or damaged.
7	The copies of various bills, i.e., bill Ex C 2 to C 81 does not lead the complainant anywhere and we have noticed that certain bills out of the exhibited bills are not authentic and bill Ex C 41, C 42 and C 43 are torn and mutilated. Even these bills are not going to prove that stocks worth Rs.7.00 lakh were lying in the shop.
8	In our considered opinion it should have been natural course of action for the complainant to have immediately called the fire brigade for extinguishing the fire, since according to the complainant was a huge fire.
9	We would like to record that each penny claimed by the complainant in his complaint has to be justified through cogent and convincing oral and documentary evidence by clearly proving the extent of damage to the stocks, building and the cause of fire. But no such evidence has been found on the file.

DROP IN PROPERTY AND ENGINEERING PREMIUM AND HOW TO NAVIGATE THROUGH THE STORM

Premium is the lifeblood of insurance. It runs the whole industry – starting from paying the fees charged by the Regulator, expenses of selling and publicity, most importantly paying claims and paying the commissions of intermediaries, and finally to expand solvency and give a reasonable profit to the owners/ shareholders.

Hence drop in premium levels is to be seen with trepidation and all should worry if the premium levels drop below the safety levels. It is true that in non-tariff markets there is the phenomena of hard and soft markets. In hard markets the premium levels go up and the insureds are penalised by heavy rates. Hard markets can come on for various reasons including shortage of capacity and lack of competition. Soft markets happen when too many insurers compete heavily and keep offering lower and lower rates for the same of level of risks that existed in the hard markets. They do this blindly for top-line growth for the short-term goals.

WHAT SHOULD BE THE RIGHT RATE FOR COVERING INSURANCE RISKS?

Actuarial principles state that rates must cover all losses, all expenses and an amount for profit and contingencies. There are also ideal characteristics for rates:

Be stable over time
Be responsive to customer risks and expectations
Provide for contingencies – a security issue
Promote risk control – motivate the insured for lowers rates
Reflect difference in risk exposure – rates must reflect exposure difference.

WHEN DETARIFFING THE REGULATOR HAD MANY CONCERNS

Competition must not degenerate into indiscriminate rate cutting. Solvency margins must not be threatened.
Underwriting should be supported by a strong technical base.
Ready availability of insurance at fair terms must be ensured.

The IRDAI had recognised at that time that there are:

- **Class Rates:** Where risks of a class have similar risk factors and individual variations are not financially significant.
- **Individual Rates**: Where each risk has significant variation in risk factors and the financial magnitude justifies individual rating.

In both cases the method should be: Start with a base rate and apply loadings or discounts for risk factors.

IMPORTANCE OF DATA

Data is the lifeblood of pricing. Data has to be captured based on various factors such as class of risk, scope of cover, risk factors present, sums insured, cause of loss and amount of claim.

Among the premium cost the most important component is the claims cost which is best expressed as ratio of claims to sums insured exposed called "burning cost." Here claims refer to incurred claims amounts and should include a suitable margin for IBNR claims.

FAIRNESS OF RATES

Section 64UC (2) (now deleted as TAC was abolished) of the Insurance Act stated a very valid point: "Ensure as far as possible, that there is no unfair discrimination between risks of essentially the same hazard, and also that consideration is given to past and prospective loss experience." The IRDAI reiterated this in their file and use guidelines. Even later the IRDAI circular dated 18.02.2016 on Guidelines on Product Filing Procedures for General Insurance Products stated in Chapter III, section III (b) "The Pricing is made based on sound actuarial calculations, supportive data and the discounts/Loadings offered are on objective basis with appropriate justifications duly certified by the Appointed Actuary."

A LARGER VISION BY EVERYONE IN THE INDUSTRY IS NEEDED

A larger vision for sound ratemaking is needed when industry players try to understand the role of insurance in society. Insurance helps to allow risk taking in the economy as it allows financial certainty in the case of losses, especially catastrophic losses. Insurance is the in the business of spreading the cost of risk: "The many pay for the few." Premium collected must cover claims risk of the entire group and not just the concerned policyholder. When premium is increased it is shared across the insured based and not just those who made the claim, though claim experience loading has a role. The law of large numbers must come into play and incentives should be provided to keep premiums affordable so that the base of large numbers can keep growing.

Today the risk for the Indian insurance industry is that at the time of large claims, there is a tendency to repudiate or pay less than the indemnity levels using various methods. This has been remarked even in the parliamentary committee report on insurance in 2024 as also that there are too many insurance disputes in the Consumer Forums.

Property and Engineering insurances generally cover larger risks and the natural catastrophes and other kinds of losses are

rising. In India the size of risks is also rising owing to the massive size of projects and new industrial clusters including giga factories. In such a situation it is incumbent on the IRDAI, GI Council and Insurers themselves to sensitise industry bodies and individual customers by way of Seminars, written material, and other promotion material on the essentiality of insurance and the solvency need for insurers as also the sanctity of risk-rating. Insurers themselves need to get together with intermediaries and resolve to rein in excessive focus on topline growth at the expense of dangerous premium deficits.

Since the days of detariffing, the slide in rates vis-a- vis the real risks in the property or interest covered, is not seen arrested and this is showing in claims ratios, claim repudiation, increased court cases and consumer forum cases. In most court cases insurers tend to get strictures and courts are enforcing the 2017 Protection of Policyholders Interest (PPI) Regulation provisions even as the IRDAI has removed all the timelines and other strictures that were there in the latest PPI Regulation. The real victor in the insurance service has to be the economy and the policyholder and not the insurer or the intermediary. If rates are not protected owing to competitive erosion, then the economy and those seeking protection will be betrayed when a real loss happens.

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