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IBAI Engages IRDAI in Progressive Dialogue

to achieve Insurance for all before 2047

The Data Conundrum

in the Indian Insurance Industry

A COMPREHENSIVE GUIDE TO

INSURE YOUR ELECTRIC RIDE

Cyber Resilience in Indian General Insurance

Navigating Threats and Opportunities

THIS ISSUE

THE DATA CONUNDRUM IN THE INDIAN INSURANCE INDUSTRY

A COMPREHENSIVE GUIDE, TO INSURE YOUR ELECTRIC RIDE

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PRESIDENT'S MESSAGE

The more things change....

Welcome to the 13th Edition of iBroker.

The New Financial year started with a big bang reform whereby the Regulator has completely abolished the tariff not only terms of pricing but in terms of policy wordings. Although the announcement led to a drop in the pricing as compared to last year which may be due to better loss ratios in the previous years. The above announcement can pave the way for further innovation in the General Insurance market which has been stagnant for decades. The Insurers has been prescribing the same policies to all the industries irrespective of the requirements and assessment of risk. I am sure Brokers along with the Insurers will have the opportunity to innovate and come out with customer friendly products which could increase the base and get more customers into the net.

I think our role will move away from price discovery to advisory based solutions and that will be true victory of the community.

Recently, we interacted with National Insurance Brokers Association of Australia (NIBA) and understood the market dynamics in Australia. Australia has a high level of penetration and the same has been achieved through better education and top class claim settlement mechanism. In fact all businesses in Australia start with minimum statutory Insurance before they embark into full-fledged business. The key to achieving greater penetration in our market remains Education and quick and hassle-free claim settlement which will not only build customer confidence but provide the necessary money for Business continuity.

The recent Master Circular on General Insurance which was published on 11th June 2024 is step in the right direction whereby Regulators are focusing on transparency, quick claim settlements, minimum paper work, better underwriting practices at the time of acceptance of proposal rather than claims underwriting. Timelines on payment of claim, survey report, penalty for non-payment of claims and awards etc.

The year started on a good note and we continue to grow at a decent pace, the last two month has seen a growth of almost 16% in General Insurance market.

In conclusion, I urge all members of IBAI to continue to uphold the highest standards of professionalism and ethics in their business practices. Let us work together towards creating a more robust and sustainable insurance brokerage industry in India.

Thank you and best wishes for a successful year ahead.

Sincerely,

Sumit Bohra
President IBAI

IBAI ENGAGES IRDAI IN PROGRESSIVE DIALOGUE; TO ACHIEVE INSURANCE FOR ALL BEFORE 2047

- *Driving solutions such as CSR spend, state level participation, composite insurance products etc. for Last Mile Penetration.*
- *Promoting Accessibility via Bima Vistaar Sales Through PoSPs (point of sales person) to Enhance Customer Reach*
- *Adopting global best practices in Indian Insurance sector*

27th May 2024 - The Insurance Brokers Association of India (IBAI) engaged in a deliberation session with the Insurance Regulatory and Development Authority of India (IRDAI) at the Bima Vitarak Manthan. During the session at the Bima Vitarak Manthan, IBAI proposed initiatives to IRDAI for enhancing insurance awareness, developing innovative products, and fostering career opportunities in the insurance sector. Recognizing brokers' significant role, contributing 35% of India's general insurance premiums and placing 20% overall, proposals included recognizing insurance spend as valid CSR, broker involvement in State Level Insurance Committees, and promoting industry-specific solutions. Key initiatives discussed were village adoption, composite insurance products, and promoting Bima Trinity for universal coverage.

IBAI put forth several key proposals, which included:

- To enable insurance, spend as a valid Corporate Social Responsibility (CSR) expenditure which will encourage corporate entities to invest in insurance awareness programs and initiatives, furthering the cause of financial literacy and inclusion.
- Insurance brokers' participation in State Level Insurance Committees and steering state-level insurance programs for last-mile penetration, extending coverage to villages through Gram Panchayats and District-level Insurance Committees.
- Fostering career opportunities in the insurance sector, especially among high school children across states.
- Promoting insurance awareness, IBAI emphasized the need for industry-specific solutions to address the unique challenges faced by various sectors. Proposals such as Adoption of villages by IBAI to promote insurance awareness,
- The development of composite insurance products, and the promotion of Bima Trinity – a comprehensive insurance solution – were discussed as part of the roadmap towards achieving universal insurance coverage.

Furthermore, IBAI outlined several recommendations to enhance the role of insurance brokers and improve the overall customer experience. These include allowing brokers to leverage technology to integrate with non-individual entities, thereby delivering greater choice and convenience to customers. They also propose reducing the educational qualification requirement from 10th pass to 8th pass, enabling brokers to self-license their direct sales teams for retail product sales, and allowing Bima Vahaks to join brokers as PoSPs(point of sales person) and vice versa. Additionally, IBAI advocates for the Bima Vistaar product to be sold through PoSPs and the adoption of global best practices such as permitting captives and MGAs, premium financing, and instalment options for premium payments across all insurance categories.

The financial services sector, particularly the insurance industry, will be a cornerstone of India's development journey. As we strive towards a developed India, it is imperative to ensure that insurance products are accessible, affordable, and tailored to meet the diverse needs of our population. IBAI has adopted five villages to promote awareness regarding insurance cover, reflecting our commitment to extending insurance coverage to underserved communities.

IBAI has committed to work closely with IRDAI and other stakeholders to drive positive change in the insurance sector and achieve the goal for 'Insurance for All' before 2047. The meeting concluded with IRDAI Chairperson calling for continued collaboration with the broker community to effectively implement the proposed initiatives, ensuring the success of India's insurance sector.

THE DATA CONUNDRUM

IN THE INDIAN INSURANCE INDUSTRY

Ashish Jhajharia

Hari Radhakrishnan

The insurance industry has always been one of the most data-driven industries, pioneering the field of data and statistics models for decades. Intelligence derived from data and statistics has been used to analyze, assess, and predict risk factors, while printed actuarial tables determine the probability of losses.

The insurance industry relied upon an innovative approach to using data, and it helped evolve the industry we see today. Although the volume of data available to insurers was vast, insurers have not been able to capitalize on it fully to gain a competitive advantage and practically approach customer centricity.

Most of this data is external to the insurer, granular, and updates with greater frequency—some even streamed in real-time—than in the past. While recent excitement about breakthroughs in AI is understandable, a fundamental question for insurers is whether their data strategy and its support data architecture will deliver the right data at the right time within the right guardrails at a scale without which the promise of better tools will never be fulfilled.

Current state of affairs

An oft repeated and cliched statement is attributed to British mathematician Clive Humby that "data is the new oil." By this statement, he meant data is like crude oil, which needs refining or processing into something more useful. The processed data can aid in business decisions, design, curate, and distribute customer-relevant products or solutions, and gain a competitive advantage.

However, over a while, this objective has been lost in many industries, including insurance. A lot of data gets collected, but they are not being used effectively, benefitting all the stakeholders, particularly the customers, from whom the data is being gathered in the first place.

Potential customers' and policyholders' expectations from their insurers have significantly increased. They want better use of their shared data to create improved value. They expect data sharing to be mutually beneficial rather than an extractive exercise, where insurers and their partner ecosystem, the data gatherers, only benefit.

Therefore, there is an expectation shift for organizations to be more proactive and adopt a more customer-empowering, partnership-based approach driven by the exchange of value.

In the above context, this article explores the current data practices in the Indian insurance industry,

- How it is being gathered,
- who is gathering it,
- what benefits are being harnessed,
- what are the challenges, and
- possible solutions so that all the parties, the insurers, intermediaries, and the insuring public benefit.

Key Challenges in data cultivation and harnessing

The challenges in data gathering are multifold. These are related to the 1st party data source (potential customer, current policyholders, and its user ecosystem), data cultivator (the insurer), and data repositories (IRDA, IIB, etc.).

At the customer end there is always some resistance to data sharing. Many a time, the information sought may not be forthcoming. This may be due to lethargy or, quite simply, unawareness. For instance, the age of the building may be asked for as part of fire insurance. Usually, customers do not make this information available. Hence, this may be kept as a non-mandatory field in the insurer's system, or a notional value may be entered where it is mandatory. This results in the unreliability of data, which is not useful for age-wise analysis of building insurance.

The insurers may face many challenges in accepting, structuring, and processing a large amount of 1st and 3rd party data, even when such data is readily available. Most insurers operate legacy core IT systems (e.g., policy admin, claims processing, etc.) with limited data capturing and processing capabilities.

For instance, legacy core systems may have challenges or limitations in assessing the spectrum of risk involved across multiple locations and customizing and processing policies covering businesses. Like banks or financial institutions that have thousands of operating locations. Therefore, such location-level data may be entered in a separate Excel file, affecting data integrity.

On the data repository front, there are a multitude of agencies operating in India.

- IRDA publishes its annual report, handbook of insurance statistics, and monthly reports on premiums made by insurers.
- IIB gathers policy level data from insurers and publishes its own reports independent of IRDA.
- The insurers also, through public disclosures, put out a lot of data.

There are neither common data standards nor any common data repository where all relevant data is available.

The data made available by data repositories is also often dated, with plenty of gaps. For instance, the IIB website gives analytical reports on fire, marine, and engineering lines of business. The latest report on their website (https://iib.gov.in/) is for 2018-19, which has reduced relevance today.

Much of the data put out by the data repositories suffers from poor granularity level issues, which makes further analysis and meaningful conclusion drawing difficult or impossible. For instance, the IRDA Handbook of Insurance Statistics has data on the number of complaints against insurance companies.

But this is not split policy-wise or cause of complaint-wise etc. So, one can't understand under which policies the complaints are coming from and why they are raised. This does not help identify the core issues of complaints and take suitable action.

Business impacts due to lack of data availability

From a policyholder's perspective, they never get to know meaningful information about the industry with irrelevant statistics. There is not much benefit for the policyholders to know about insurance companies' health insurance claims settlement ratio. What they would be interested in knowing could be the following:

- The average time taken to settle a claim,
- The time taken to approve a cashless request,
- The average difference in the amount billed by a hospital to the amount sanctioned.

Failing to address the limitations of data availability results in...

Without meaningful statistics that the customers can use, mistrust in insurance gets built instead of trust, adversely affecting insurance penetration.

From a regulatory perspective, the right kind of data analytics and its visualization can help them create a dashboard, which helps them understand the market development on various parameters. They can understand the pain points and bottlenecks, which can help them develop informed strategies to combat them.

The insurers can also greatly benefit from more robust and granular data. Due to a lack of quality data, many products are not priced properly or otherwise done on a trial-and-error basis. Recently, an insurer withdrew a popular health insurance product due to high claims ratio.
It is possible that the insurer relied on poor-quality data to support its pricing, and the assumptions went wrong. To err on the safe side, many insurers do not attempt to underwrite certain products due to a lack of market data. With data availability, such avoided products could become writable, and customers could benefit.

Why does the customer/policyholder hold the key here?

The Indian general insurance market was historically tariffed in a market dominated by public sector (PSU) insurers. Life insurance was monopolized by the Life Insurance Corporation of India (LIC). The market was paternalistic, with the insurance companies acting as an extended arm of the government. Through their market agreements, the tariff advisory committee (TAC) and insurers decide what products customers should consume.

With the market opening to private competition, the number of players and the insurance products and solutions available to the customers has expanded. Insurers have become more open to new product development. However, customer participation in data usage and management in the insurance sector has not improved.

Customers and their interest groups, like consumer protection organizations, need to get their seat at the table. They need to seek participation in how data gatherers are employing their data. They must ask how their supply of data is benefiting them in return. There will be visible changes when the market demands results rather than being passive data suppliers.

Insurers and regulators must find motivations and design enough incentives for potential customers and incumbent policyholders to share their data more pre-emptively and proactively.

Data culture is the only religion for insurers.

Approximately 90% of all data was created in the past two years, with 2.5 quintillion bytes of data created daily.

Starting in the mid-2000s, many insurance companies incrementally improved their ability to utilize data thanks to advancements in data infrastructure and analytics technologies and rethinking of the silo mentality that hindered enterprise-wide data strategies.

However, these gains were mostly confined to the operational data that insurers already collected, such as policyholder details, customer interactions, payments, claims, etc. Moreover, the focus was on traditional processes—i.e., annual policies sold through brokers/agents or direct channels and infrequent engagement with end buyers. Some insurance players continue to grapple with the challenges posed by the first insurance data revolution.

The next insurance data revolution is fuelled by the explosive growth of new data from much deeper 1st party and wider 3rd party sources such as potential customers and current policyholder ecosystems, satellites, sensors, social media, digitized records, and even synthetic data platforms.

Many large regional, local, and MNC insurers in Southeast and Far-East Asia understand the pressing need for a robust data strategy or review and reinvent if they already have one such strategy. In this process, they took a couple of interesting steps:

- Understand what data and the level of its granularity they would require to support their changing business model better to serve potential customers, current policyholders, and intermediaries and operate with more process efficiencies and decision effectiveness.
- What would these potential data sources be (1st party, 3rd party, or so), and how will they get it from these sources?
- What data architecture design would support their new/future data strategy to future-proof themselves?
- They reassessed all the data they gathered in the last couple of decades and are currently capturing and removing the useless and garbage data from their hold.
- What will be an optimum data strategy to curate, cultivate, and harness these data on a perpetual basis so that the required data pipeline can be scaled with a consistent flow of the right data with the right level of required granularity across the insurance value chain and the entire partner ecosystem.
- Whether their current core system is designed and capable enough of capturing, analyzing, and processing these required new data sets, otherwise how do they replace it with a newer, modern, robust, scalable and data-centric core system that can support new data strategy and enable decision automation, interoperability and straight through processing (STP) across the insurers' value chain.
- They have started modernizing their entire tech ecosystems, making them more API-first and API-centric.

This data culture orientation is the core focus of their transformation journey, and many of these insurers are spending solely over US$ 50 million over the next couple of years on these data strategy and architecture initiatives to achieve meaningful goals.

What must be done in the short-term and for the long run

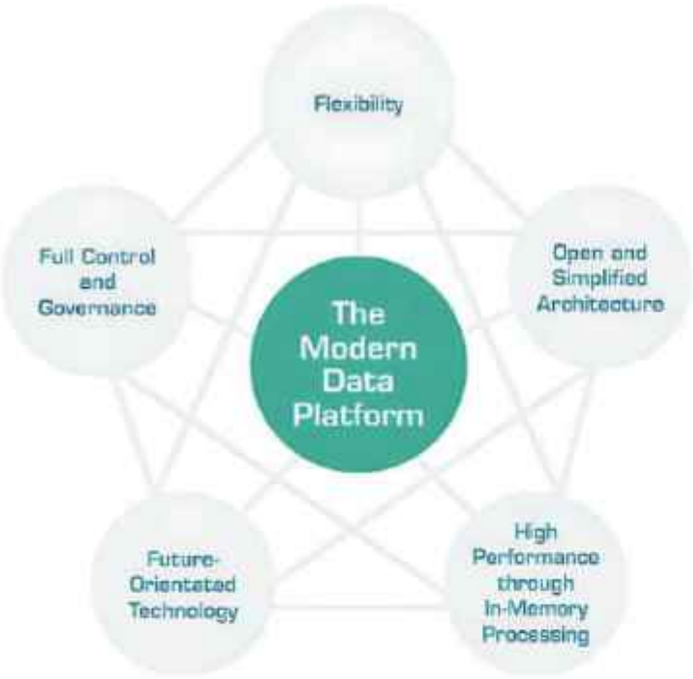
IRDA, which is mandated to regulate and develop the insurance market in India, must take the lead in data management in the industry. Instead of multiple sources of information, one agency, the Insurance Information Bureau (IIB), should gather and disclose all data in the public domain, avoiding duplication of efforts.

IIB should engage with stakeholders, including researchers, to identify the industry's data needs that must be put in the public domain. A clear and well-defined data disclosure strategy must provide the general public with maximum transparency and granularity of data. Public awareness of the importance of giving data to insurers should be greatly improved. Confidence should be built in the general public that the data they share is being used responsibly and not being put to any use that does not serve the customer interest.

Once the framework for data repository and analytics for general use is finalized, the IIB should work with insurers and other data gatherers to ensure quality data is put out in the public domain. The data should be published on a timely basis without undue delays. Old and dated data is as good as having no data at all.

Business Benefits delivered through AI and data analytics

Every $ investment in technology must result in some tangible business benefit realization for insurers, and investment in data transformation initiatives will lay down the foundation of the achievable AI-Journey and enable them to become a data-first insurer.



Insurers are already struggling with asking for information repeatedly from policyholders while at renewals, endorsements, or even for cross-selling and up-selling. With the help of data transformation, insurers' tech landscape will start becoming more intuitive and smarter for operations-level folks, intermediaries, policyholders, and potential customers.

Business benefits will start pouring in across its value chain with such a data transformation strategy and operationalization.

- Some of the early gains for insurers will come as insurers can drastically reduce the "omitted disclosures, " reducing the policy cancellations, claims delay/denials, and associated customer effort.

- To solve these pain points, insurers must adopt accelerated standard UW processes based on disclosures and available data. By implementing a smart pre-UW system using sophisticated predictive models, insurers can achieve a higher automatic approval ratio at the point of sale and reduce or eliminate the UW at the time of claims.

Conclusion

The insurance industry thrives on data. To meet the demands of the market's evolving needs, all players in the insurance industry need access to reliable and quality data with the requisite granularity. Generation of such data requires purposive action from the players, led by the regulator, to lay down the framework for gathering, standardized formats for data collection, and dissemination to the public at timely intervals. Disclosure of relevant and contextual data builds customer trust and motivates them to share it voluntarily. The insurers, in turn, benefit from such disclosure by using data to develop innovative products and solutions for the customers. A well-thought-out data strategy can be a win-win for all the stakeholders in the insurance industry.

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A COMPREHENSIVE GUIDE, TO INSURE YOUR ELECTRIC RIDE

Electric Vehicle's Landscape in India:

- The electric vehicles industry at a nascent stage in India. It is less than 1% of the total vehicle sales, however, has the potential to grow to more than 5% in a few years. Many serious players (Hero Eco, Ola Electric, Ather, Electrotherm, Avon, Lohia, Ampere, etc) are continuing with the mission and trying to enforce the positive change. The industry shows immense potential to drive change, provide a brighter and more eco-friendly future for India and contribute to global efforts to combat climate change and create cleaner, healthier cities.
- The India electric vehicle market size is projected to grow from USD 3.21 billion in 2022 to USD 113.99 billion in 2029, growing at a compound annual growth rate of 66.52 per cent, according to a report by Fortune Business Insights.
- The Indian EV battery market is also set to skyrocket, from $16.77 billion in 2023 to an impressive $27.70 billion by 2028. With the emergence of smart battery (Lithium -ion) pack swapping solutions providers like Sun Mobility Pvt Ltd has further enhanced the energy infrastructure to accelerate the mass adoption of electric mobility.
- In a remarkable milestone, India achieved over 1 million EV sales in less than nine months in 2023, a feat that took an entire year in 2022. Data from the Ministry of Road Transport and Highways indicates that these EV registrations accounted for 6.4% of total automobile sales in the country.
- In 2023, the two-wheeler segment accounted for 56% of EVs sold, closely followed by three-wheelers and passenger vehicles. Notably, CY2022 was the first year when EV sales in India had charged past the million-unit mark. Fleet operators played a crucial role in this milestone, as they contributed substantially, accounting for roughly 25 percent of all EVs sold in 2022.

- India has set an ambitious target of increasing the share of EV sales to 30 per cent in private cars, 70 per cent in commercial vehicles, 40 per cent in buses, and 80 per cent in two-wheelers and three-wheelers by 2030. In absolute numbers, this is estimated to translate into an impressive target of 80 million EVs on Indian roads by 2030. The country also aims to achieve 100 per cent local production of EVs under the 'Make in India' initiative.
- India sees a great opportunity with EVs in reducing the Carbon footprint, dependence on Crude oil imports, creating jobs and building a new Technology knowledge hub in the country

Risk Exposures in Lithium-ion Batteries:

- **Risk of 'Thermal Runaway':** If a lithium-ion battery is overheated or overcharged, it can experience a rupture and a failure called "thermal runaway". Thermal runaway is a situation where increasing temperatures in the battery start releasing energy, which then generates heat and continues to increase the temperature of the battery. This uncontrolled process sometimes results in combustion, and lithium-ion batteries are especially susceptible to such a failure.
- **Risk of 'Fire on Impact':** In certain circumstances – if the battery has been damaged by dropping, piercing or even heavy jolting, for example - a fault inside the battery can be triggered, causing it to short circuit. Lithium-ion battery fires are incredibly dangerous and can be difficult to deal with because they release flammable and toxic vapour which helps to further fuel the fire.

- **Risk of Fire and Injury while charging or parked:** When an electric vehicle is parked, it is not de-energized. It is always on and ready to go, unlike gasoline-powered vehicles, which are shut down and disengaged within a few minutes of being turned off. There is a risk posed by electric fault and electric malfunction in a vehicle that is always on and never really turned off. Mass-produced cables that are not properly insulated or have exposed wiring from usage or copper-theft, standing water, and damaged units all contribute to the potential of electric shock. At-home charging stations also pose a risk if they have not been installed safely.

- **Risk of Severe Injuries during Collision:** In order to extend driving distance and battery life, electric vehicles are designed to be as light as possible. When two cars going the same speed crash front to front, the outcome depends in part on the cars' relative weights. The heavier gas-powered car will push the lighter electric car backward during the impact, which means the velocity change of the heavier car will be much less than that of the lighter car. If the lighter car weighs half as much as the heavier car, the force on its occupants will be twice as great.

- **Risk to Third party Pedestrian:** Electric vehicles are extremely quiet. The downside of this feature is that it may pose injury risks to pedestrians as the electric vehicle is mostly silent outside of the cabin as well, even when in motion. Lacking the audible indications a battery powered vehicle would be making, pedestrians can be unaware of the proximity or movement of an approaching electric vehicle. That risk is elevated in a number of situations including noisy, urban streets, and potential incidents that involve children, cyclists, and visually impaired pedestrians.

- **Risk of Disposal:** When a battery-powered electric vehicle is involved in a collision, the battery needs to be removed, discharged, frozen and then destroyed. Disposing of a vehicle's large, lithium-ion battery can be a costly affair

Risk Identification and Mitigations-EV:

- Emergency Response Plan to tackle overheating or damaged lithium-ion batteries.
- Do not expose the battery to condensation, excessive humidity, or water. Never stack heavy objects on the top of the batteries or device containing batteries.
- Charge lithium-ion battery powered units in a non-combustible structure/room located outside the main building or attached to the external wall.
- Charging inside the main building requires a minimum of four meters clearance from all combustibles and charging to be interlocked with localized or premises fire detection to shut off the power to the charger bay and raise a fire alarm.
- Ensure all charging is completed during working hours. If battery charging is undertaken out-of-hours, additional expensive control measures are recommended such as dedicated fire-rated cabinets or battery charging rooms, early alert off-gas detection and localized automatic fire suppression such as water mist protection to contain fire spread.
- If the battery is detachable, remove it from the equipment when it's not in use for extended periods. Lithium-ion batteries not in use must be stored in a cool, dry location, in a charged state.
- In industrial or vehicle workshop premises, where the State of Charge (SoC) can be checked or changed, the batteries should be stored at 30% SoC if kept for extended periods, and certainly no more than 50%. This is because the energy in a fire situation has been found to be significantly less at 30% than if the SoC is above 50% and it makes fire-fighting much easier.
- Segregate lithium-ion batteries from other materials if bulk-stored in a warehouse, in a non-combustible, well-ventilated structure /room with sufficient clearance between the walls and the battery stacks. There should be clearance between batteries to allow air to circulate.

- Control floor stacking of lithium-ion batteries in designated areas with limited stack heights, footprints, and separation distances. Rack storage of lithium-ion batteries should not be permitted unless the building and the racks are fully sprinklered with solid metal horizontal and vertical barriers between each storage bay.
- Use a hand-held IR gun to perform thermography inspection for any battery that has or may have sustained damage. Any deviation from the normally expected general temperature by 3°C or more on any individual lithium-ion battery package should be reported to management immediately so the pre-defined emergency response action plan can be initiated.
- Maintain a steel bin partially filled with water (or similar arrangements) at least three meters clear of the building, in readiness for any lithium-ion batteries with elevated temperatures to be placed into by a forklift truck. Other fire containment materials such as vermiculite or sand can be used to smother the affected battery. These measures might not stop the chemical fire from continuing, but they will assist with fire containment.
- Never open, destroy or incinerate a lithium-ion battery as it may leak or rupture and release the ingredients they contain into the environment. Any swollen, dented or otherwise damaged batteries should be recycled or disposed of by a company qualified to do so.

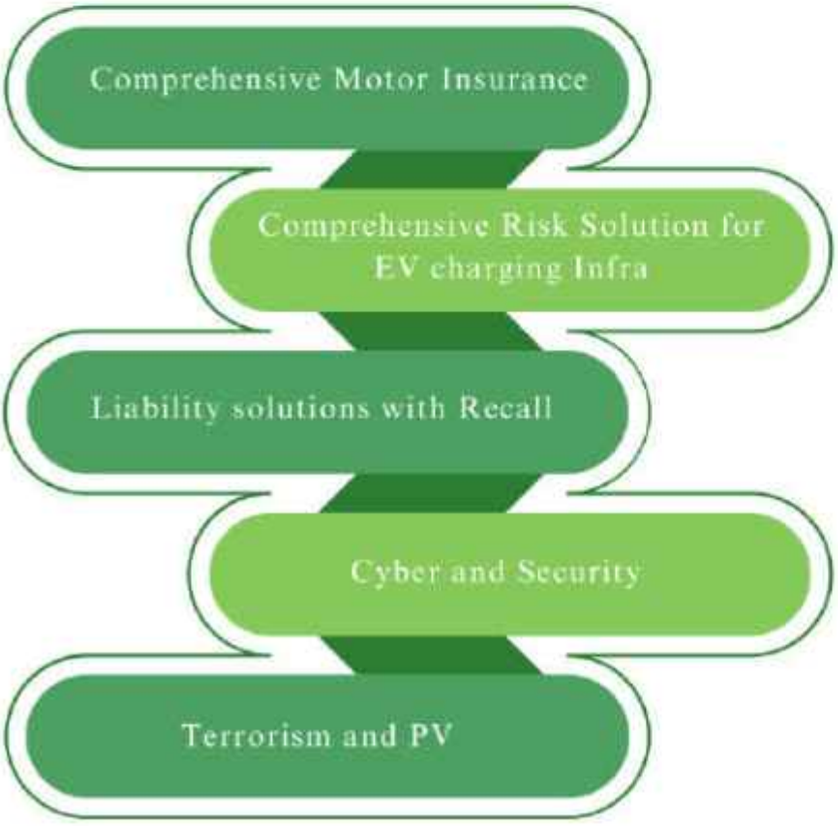
Factors to be Considered while Insuring EV Risk:

- **Replacement/Repair Cost:** One of the main considerations when insuring electric vehicles is the potentially higher cost of repairs. EVs often come with specialized components like lithium-ion batteries, which can be pricey to replace or fix in case of damage.
- Availability of Spare Parts: Some makes and models might have limited access to replacement parts, especially for older or less popular EVs. This can affect both repair expenses and turnaround times.
- Technology and Safety Features: Many electric vehicles are equipped with advanced technology and safety features, such as autonomous driving systems and sensors. While these features improve safety, they can also drive-up costs for repairs or replacements, impacting insurance premiums
- Battery Degradation: Over time, the capacity of an electric vehicle's battery can decline. Some insurance policies may need to account for factors related to battery lifespan and replacement expenses.
- Chargin Points Infrastructure: Insurance considerations might also relate to the availability of charging infrastructure. The accessibility of charging stations can affect the risk of running out of power and drivers potentially being involved in an accident.
- Model Specific Factors: Specific makes and models might have unique features or vulnerabilities that impact insurance rates. For instance, certain models could be more prone to theft or specific types of accidents.
- Market Value and Salvage: The value of electric vehicles can fluctuate, and it's crucial for insurance providers to accurately assess the current worth of the vehicle for coverage purposes.

Comprehensive Insurance Solutions: EV

A proactive Risk Manager can help manage EV Risk Challenges via Insurance Solutions such as:

- **Comprehensive Motor Insurance Solutions** for Vehicles and Fleet.
- **Fire and Allied Perils with Contingent Business interruption** for Lithium -Ion batteries Manufacturers, charging Infrastructure and storages premises to ensure smooth supply chain management.
- **Third Party Liability:** Those who provide charging points are liable for third parties and their property. If fire results in a customer's car being damaged or destroyed or if somebody is injured using a charging cable, you need to ensure you have protection in place in the form of third-party liability.
- **Cyber** - EV and charging technology utilises software that has the potential to be hacked by cybercriminals, so you need to ensure you have some form of cyber protection in place.
- **Security** to protect against vandalism and theft of cables, it's essential to think about the location of charging points, utilising such safety measures as locking barriers, and having the necessary insurance cover.
- **Terrorism and Political Violence:** Physical Loss or damage to insured property arising out of insured perils but not limited to an act of terrorism or Sabotage, RSMD, Civil Commotion etc.



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CYBER RESILIENCE IN INDIAN GENERAL INSURANCE:

Navigating Threats and Opportunities

Jatin Punjani
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Profound Risks Services LLP

The Cost of Cybersecurity: Overcoming IT Infrastructure Challenges in the Face of Growing Threats

In today's digital age, cyber-attacks have become increasingly prevalent, posing significant challenges for businesses of all sizes. One of the critical barriers to effective cybersecurity is the cost associated with securing IT infrastructure. India has witnessed overall 23% cyber-attacks in last year and have ranked in top 10 country this year, Despite the escalating frequency of cyber threats, many companies, including corporates, Mid-size & MSME's are reluctant to invest in cybersecurity measures due to the perceived financial burden.

The reality is that cyber-attacks occur on a day-to-day basis, targeting organizations across various industries. Hackers exploit vulnerabilities in IT systems to gain unauthorized access, often with the intent to collect sensitive or confidential information and demand for ransomware resume Denial of Service and further business interruptions from there control.

Implementing cybersecurity measures, such as antivirus software, firewalls, and employee training programs, undoubtedly incurs costs for MSMEs & Mid-size companies. However, these investments are crucial for protecting sensitive data, maintaining operational continuity, and preserving customer trust. There are affordable cybersecurity services available, their offers include consultation along with cost of implementation up to minimum INR 10 Lakhs. These services offer tailored solutions designed to meet the specific needs and budget constraints of smaller businesses, providing essential protection against cyber threats.

In addition to implementing cybersecurity measures, corporates can also mitigate their risk exposure by obtaining cyber insurance coverage, by sharing Cyber security assessment reports, most of the Insurance Brokers are helping their clients with such reports and implementation solutions. Real time Reports provide insurers with comprehensive insights into an organization's cybersecurity posture, vulnerabilities, and risk exposure. Insurers can gain a deeper understanding of an insured's risk profile and assess their eligibility for cyber insurance coverage with right premium and wider coverage's, therefore, the overall cost invested to improve IT systems plus cost of Insurance can buy them coverage protection for the crores of rupees, which can help corporates to sustain in their business for longer run and at the same time corporates get recognized by adhering as part of ESG (Environmental, Social and Governance) policy, also comply as vendor under ERM (Enterprise Risks Management) policies.

"Cyber Insurance Dilemma: Understanding the Rising Costs and Shrinking Capacity"

Understanding Cyber Insurance Losses:
Cyber insurance policies encompass various covers, including incident response, forensic investigation, Reputational injury, IT consultation fees & Costs, liability towards third parties & regulatory actions. Each of these covers can result in substantial losses for insurance companies, particularly when multiple claims arise under a single policy. Minimum loss including incident reporting, forensic and other costs sum up to INR 10 Crores to 15 Crores, for big corporates claim amount increase significantly.

Emerging Trends in Cyber Claims:
While ransomware attacks have garnered significant attention globally, India has predominantly witnessed cyber claims stemming from data breaches and malware incidents. Although large corporates often have robust IT infrastructures, they face challenges in managing cyber risks associated with vendor management. Vulnerabilities in vendor IT systems pose significant risks, as most of their vendors are from mid-size to MSME's companies.

Need for Enhanced Risk Management:
To address the evolving cyber risk landscape, large Corporates must prioritize ERM and strengthen vendor management programs. Investing in ERM frameworks helps organizations identify, assess, and mitigate cyber risks effectively. Moreover, robust vendor management practices are essential to mitigate risks.

Challenges in Cyber Insurance Underwriting:
The surge in cyber claims has put immense pressure on insurance companies, leading to a tightening of underwriting standards and a reduction in capacity. Insurers face challenges in accurately pricing cyber insurance policies to reflect the true extent of cyber risks and potential losses. Indian General Insurance have limited capacity and cyber underwriters.

Collaborative Approaches to Risk Mitigation:
Addressing the challenges in the cyber insurance market requires collaborative efforts between insurers and Brokers. Insurers can work closely with their Brokers to address their clients to enhance cyber risk awareness, implement robust cybersecurity measures, and develop tailored risk management strategies. Collaboration fosters transparency, trust, and proactive risk mitigation, ultimately reducing the frequency and severity of cyber claims.

"Navigating Sanction Countries Limitations in Cyber Insurance: Challenges and Solutions"

The escalating cyber threat landscape, coupled with stringent legal compliance requirements, has posed significant challenges for insurance companies when offering cyber insurance coverage to sanction countries. With countries like Ukraine and Russia ranking high in cyber-attacks, insurers face pressure from reinsurers and legal compliance mandates to exclude coverage for losses arising from these jurisdictions. This presents a complex dilemma for insurance brokers and policyholders alike, as they grapple with the implications of limited coverage options and the need to safeguard against cyber risks in high-risk regions.

Despite these challenges, innovative solutions have emerged to address the limitations imposed on cyber insurance coverage for sanction countries. Some insurers offer coverage with limitations tailored to the specific exposure and compliance requirements, allowing policyholders to mitigate their cyber risk exposure while complying with legal regulatory mandates. Additionally, insurance brokers play a crucial role in navigating these complexities by advocating for their clients and leveraging their expertise to secure coverage through alternative avenues, such as reinsurance markets or placing local policies with help of network partners. By conducting thorough legal, compliance checks and evaluating exposure levels.

"India's National Cyber Security Strategy: Initiatives and Progress"

India has taken significant strides in fortifying its defenses against cyber threats, exemplified by the establishment of various policies and bodies dedicated to cybersecurity. The National Cyber Security Policy stands as a cornerstone, providing guidelines for both citizens and businesses to safeguard cyberspace information and IT infrastructure. Complementing this policy is the Cyber Surakshit Bharat Initiative, aimed at raising awareness among Chief Information Security Officers (CISO) and frontline IT teams across government verticals. Moreover, the inception of the Indian Cyber Crime Coordination Centre (I4C) has bolstered the nation's response to cybercrimes, offering a comprehensive framework for law enforcement agencies. Furthermore, initiatives like the Cyber Swachhta Kendra and the Computer Emergency Response Team - India (CERT-In) demonstrate India's proactive approach in mitigating cyber threats by detecting, cleaning, and securing systems from malware and botnet infections & last but not the least, introducing Digital Personal Data Protection Policy known as DPDP Act 2023.

However, as the digital landscape evolves, India recognizes the need for continuous enhancement of its cybersecurity capabilities. Strengthening the existing legal framework and fostering collaboration between public and private sectors through a dedicated Cyber Security Board are paramount. Additionally, enhancing partnerships on an international scale with organizations like the United Nations and The International Telecommunication Union will further fortify India's cyber resilience. By prioritizing these strategies, India is poised to navigate the increasingly complex cyber threat landscape and safeguard its digital assets effectively.

Anatomy of an

INSURANCE POLICY

There are many kinds of insurance policies varying in terms of length, complexity and the nature of the risk insured. However, almost always policies follow a similar structure of contents.

The insuring clause

This clause lists perils covered, but in all risks policies, rather than perils, all losses excluded have to be specified, otherwise they are deemed to be covered.

Exclusion Clauses

Exclusion clauses specify loss or properties or locations etc. that are excluded. However, there can also be silence relating to some perils and these are known as "uninsured perils" and they are not specifically excluded. The distinction between excluded perils and uninsured perils is reflected in common law rules on causation: a loss concurrently caused by an insured and an excluded peril is excluded and not recoverable, whereas a loss concurrently caused by an insured and an uninsured peril falls within the policy. Refer the case *Global Process Systems Inc v Syrikat Takaful Malaysia Berhad, The Cendor Mopu [2011] UKSC 5; [2012] 1 All E.R. (Comm) 111.)*

Triggers of Coverage

There may be one or more triggers of coverage requiring satisfaction before cover attaches.

- The first is the "injury-in-fact trigger" in which the coverage trigger is the injury or the loss itself. For example, a fracture of a body bone such as a leg is proof of coverage.
- The next is the "manifestation trigger" which refers to the moment in time in which the policyholder becomes aware of a loss for filing a claim. There is also the 'discovery period'. Typically, discovery period is the period of time after the policy has expired which allows an insured to identify and report losses occurring during the period of a policy. Thus, if the manifestation happens after the policy period, the cover is not available unless the policy has been renewed or there is an extended claim reporting clause.
- Another is the "Exposure Trigger" which applies to injuries that manifest over time, such as those caused by breathing in harmful chemicals. It may take years for the injury to appear, but courts may consider the original period of the exposure (e.g. when the injured party was first exposed to the chemicals) as the point of claim.

- The last is the "Continuous trigger", which is a combination of trigger types – manifestation, exposure, and injury-in-fact – leading to an injury that develops over time. This type of trigger is used to ensure that the insurer's obligations are not diluted. For example, a food manufacturer used a preservative to increase the shelf life of one of its products. This preservative was later found to cause health problems, though it took years for the illness to develop.

Conditions

Conditions are another important part of the policy. They are obligations to which the insured must comply. In conditions insurers seek to rely upon terms which state non-liability for a particular claim. In any policy, determining the status of a contractual term is vital to establishing the insurer's rights upon breach of that term. Depending upon the breach the remedies can range from a right to terminate the policy, refuse a claim or simply seek damages. The normal area for debate is whether or not a "condition" has been unambiguously expressed in the policy and also whether it is a condition precedent.

If a clause is stated to be a condition precedent as to liability, then breach of that condition will nearly always give rise to the insurer being able to refuse a claim. Claims procedure conditions are often stated to be conditions precedent to an insurer's liability, such a for example conditions providing for notification of a claim within a specified period.

Warranty

The word "warranty" causes considerable confusion, as it is used in many different senses. In general contract law, a warranty is normally a term of minor importance, and a breach of warranty gives rise only to damages. Within the insurance industry, however, the term refers to strict obligations placed on the insured. The insured must comply with them strictly or face harsh consequences. The main characteristics of a warranty within insurance law, are set out in the Marine Insurance Act (MIA) 1906.

A wide variety of obligations on the insured can be given warranty status if the policy makes this sufficiently clear. Section 33(1) of the Marine Insurance Act (MIA) 1906 describes "promissory warranties" as terms by which the assured undertakes that some particular thing shall or shall not be done, or that some condition shall be fulfilled, or whereby he affirms or negatives the existence of a particular state of facts. In other words, warranties may apply to past or existing facts, or to future conduct.

The MIA states that a warranty "must be exactly complied with, whether it be material to the risk or not". So, if an insured has "warranted" that certain facts are true, the warranty will be broken even if the answer made no difference, or if the insured was not at fault in any way. The insurer will be discharged from liability, if an insurance policy warranty is breached.

Receipt of Premium

Receipt of premium is necessary for a policy to be valid. This is essential in the Indian context.

Endorsements or Rider

An endorsement, also known as a rider, adds, deletes, excludes or changes insurance coverage. An endorsement/rider can also be used to increase standard limits of coverage and endorsements take precedence over the original agreement or policy. An insurance endorsement/rider is an amendment to an existing insurance policy that changes the terms of the original policy. An endorsement/rider can be issued at the time of purchase, mid-term or at renewal time. The premiums may be raised or refunded or adjusted as a result.

Countering the cost of increasing Health Insurance premium

Health insurance is the bearing of uncertain health risks by an insurer, using the law of large numbers. The core concept of insurance is that everyone who wants protection pays a premium based on their risks, and a pool of funds is created from which the few who face losses due to the covered risks are indemnified. The duty of the insurer is to minimise risks so that the pool is viable and those who paid premiums are indemnified. Hence insurance is not a function of mere standardized payouts but careful indemnification on a case-by-case examination to ensure that only reasonable and necessary indemnification is paid. One of the important objectives of the prudential approaches of all insurance coverages is to make premium affordable and to ensure that no one profits from claim payouts.

The subject of health insurance is complex because it attempts to indemnify the costs of human morbidity conditions, which are uncertain, subjective, dynamic and inflation oriented. Unlike the traditional property insurance where risks are often static, objective and with standard rates for indemnification; health insurance presents grave complexities in many areas. It is a frequency risk, in that occurrence of claims is much higher in health than in many other insurances. It is a period risk, meaning there is a continuum of costs from the time of admission till discharge, with possible complications in between which can escalate costs, and hence the final cost is often subjective. This means that two persons in a similar risk bracket will fall ill for a named disease but with different cost outcomes owing to factors such as the length of stay and complexity of treatment and the possibility of various levels of complications. The cost of treatment will thus vary based on the vast variety of morbidity conditions, but also additionally depending on the type of hospital, whether government, not for profit or commercial hospital, and whether the hospital is in primary, secondary or tertiary (including super specialty care), and in what geographical location the hospital is located as costs will be high in a metro like Mumbai or Delhi, and less costly in tier II or III cities.

In health insurance, insurers face four types of additional insurance risks. They are adverse selection, moral hazard, fraud and inflation. In the claims area moral hazard tries to defeat insurers. Moral hazard is called 'hidden action' and here the insured or other claim billing entities can abuse the facility to get a gain from insurance. Health insurance is prone to a double moral hazard as there is incentive both for the insured and the medical service provider to claim/charge more than what is 'reasonable and necessary' as per the principle of indemnity.

Rise and Rise of Health Care Costs

Experience indicate that health care costs will rise owing to general inflation, due to improved technology and treatment practices as also increased consumption of healthcare services. Therefore, every effort must be taken by insurers and stakeholders like medical care providers so that premiums remain affordable and, in this regard, there is a compelling need to regulate standards and costs on the part of the medical providers such as using ICD 10 or 11 codes and so on to make costs objective, transparent and auditable.

Experience indicates that wherever groups and governments organises large group insurances, which are called tailor-made policies, every such entity requires the insurance company to organise a policy with a varying menu of coverage offerings. Hence all large schemes are seeing differing benefit coverages and indemnities, and there is no convergence to any one model of indemnity. Many of the mega-group policies are also able to enjoy lower rates and better terms.

How to Keep the Rise of Health Insurance Premium in Check

Taking a cue from the tailormade policies and mega policies, it is clear, that insurers and others can draw lessons on ways to keep the rise in premium in check. There are continuums which show that premium can fall as the type of cover move forward. Examples

High to Lower Costs

- **Numbers enrolled:** Individual insurance to Family insurance to Family floater to group insurance
- Type of hospitals: Super-specialty hospital to Private for-profit hospitals to non-profit hospitals to government hospitals
- **Technology**: High tech-based treatments vs standard type surgeries and treatments
- **Type of cities:** Metro cities, to other big cities to district headquarter and local hospitals
- **Age basis:** Senior citizen to mid-life age to young age
- **History of diseases:** pre-existing disease to bad heath indicators such as BMI, to no past-history and good health as of now
- **Type of cover:** All types of diseases and morbidities, or only critical care diseases
- **Choice of deductibles and co-pay**
- **Based on sum insured:** Very high to lesser amounts
- **Percentage of Claim payout:** at least 80% claim payout should be mandated
- **Fraud Prevention**
- **Other costs** – taxes, TPA charges etc.

Based on such factors as above, it is the duty of insurer and the intermediary to advise their customers suitably. Once the customer enters a health insurance scheme, preferably at a young age, the customer must be convinced to stay insured and avail all the benefits of continued insurance by renewing in time, and migrating seamlessly from one type of policy to another such as from an employer group insurance to individual or family insurance after retirement and so on. It is important to come out of the clutches of pre-existing condition clause and even get into the post-moratorium period, where no questions will be asked on pre-existing illnesses or conditions.

Affordability is again a factor of wealth and well-being and as people rise in their income status, they need to opt for higher sum insured and better modes of treatment and services and should not shy away from the cost of paying a higher premium.

Employees' Compensation (WC) for all unorganised and SME sector workers – Need to increase the Liability Book Ground- up

One of the most easy and necessary insurance for the unorganised and SME sector is the Employee Compensation (EC) Policy. Worldwide, EC policies have to be taken for construction workers as the frequency of accidents can be quite high. Thus, there is need for this insurance from the angle of both employer and employee. Policies can be on group basis and it can be on unnamed basis as well, if all are covered and a register is maintained. The final premium is also adjustable at the end of the policy period.

The Employees' Compensation Act, 1923 introduced legal protection for accidents and occupational diseases that may take place whilst in employment. It enables an employee, or in case of death of an employee, his dependents, to get, at the cost of his employer, compensation for employment injury. \
Generally, every Employer employing persons listed in Schedule II to the Act; carrying on an occupation listed in Schedule III to the Act is liable to pay compensation under the Act.

Under the Act injuries are broadly classified into five groups as those resulting in: -

1. Death,
2. Permanent Total Disablement,
3. Permanent partial disablement
4. Temporary disablement whether total or partial
5. Contracting an occupational disease.

Conditions for Receiving Compensation

An employee to whom personal injury is caused by accident is entitled to receive compensation under the Act if the accident arose out of and in the course of his employment. That means the accident must occur while the employee is in employment and it must also be connected with his employment.

The employer is not liable to pay compensation for injury to an employee in the following circumstances;

1. If the injury does not result in total or partial disablement of the employee for a period exceeding three days;
2. If the injury does not result in death of the employee and is caused by an accident which is directly attributable to:
3. The employee being under the influence of drink or drugs.
4. Disobedience of the employee to an order expressly given, or to a rule expressly framed, for the purpose of securing the safety of workman, or
5. Wilful removal or disregard by the employee of any safety guard or other device which he knew to have been provided for the purpose of securing the safety of employee.

Amount of Compensation

When the injury to an employee results in his death, the amount of compensation payable to his dependents is an amount equal to 50% of the monthly wages of the deceased employee multiplied by a figure ranging from 228.54 to 99.37 (depending upon the age of the deceased employee as per table given in the Act) or an amount of 1,20,000, whichever is more. However, if the monthly wages of the deceased employee exceed Rs. 8000/-, his monthly wages for the purpose of calculating the compensation shall be deemed to be Rs. 8,000/- only.

Amount of Compensation Received in case of permanent total disablement: When the injury of an employee results in his permanent total disablement, the amount of compensation he is entitled to receive is an amount equal to 60% of the monthly wages of the injured employee multiplied by a figure ranging from 228.54 to 99.37 (depending upon the age of the injured person as in the Act) or an amount of Rs. 1,40,000/- whichever is more. However, if the monthly wages of the injured employee exceed Rs. 8000, his monthly wages for the purpose of calculating the compensation shall be deemed to be Rs. 8,000/- only.

When the injury of an employee results in his permanent partial disablement, the amount of compensation he is entitled to receive is a percentage of the compensation payable in the case of permanent total disablement. The percentage is determined with reference to the extent of loss of earning capacity caused by the injury and is a lumpsum payment.

In case of Temporary Disablement

When the injury of an employee results in his temporary total disablement or temporary partial disablement he is entitled to receive compensation in the form of a half-monthly payments. The amount of a half-monthly payment is determined with reference to the monthly wages the employee was drawing at the time of the injury and is equal to 25% of the monthly wages of the employee. The maximum period during which the employee can receive compensation for temporary total disablement or temporary partial disablement is five years.

A new provision in the Act entitles an employee to the reimbursement of actual medical expenditure incurred by him for injuries caused during the course of employment.

Payment of Compensation in case of Fatal Accidents

Payment of compensation in respect of employee whose injury has resulted in death is not to be made directly to the dependents of the employee. In such case the employer is required to deposit the amount of compensation with the Commissioner for Employee's Compensation. The Commissioner will then apportion the amount among the dependents of the employee. It is held that the payment of compensation directly to a dependent is not legal even if he is the only dependent of the deceased employee claiming compensation.

Protection of Compensation

Compensation payable under the Act, whether in the form of a lump sum or in the form of a half–monthly payment, cannot be assigned, charged, attached or set-off against any claim.

Special Powers of the Commissioner in respect of Lumpsum Payment

Where any lumpsum compensation is payable to an employee or a person under a legal disability, the employer must deposit it with the Commissioner for Employee's Compensation. It is open to the Commissioner to invest such sum for the benefit of the woman or of such person during his disability.

Special Powers of the Commissioner in respect of Half-Monthly Payment: Where any half-monthly compensation is payable to a person under a legal disability, it is open to the Commissioner for Employee's Compensation to order that such payment be made during the disability of the person to any dependent of the Employee or to any other person best fitted to provide for the welfare of the Employee.

Report of Fatal Accidents

If any accident occurs on the premises of any employer which results in death of an employee or serious bodily injury to an employee, the employer must, within 7 days of the death or serious bodily injury, send in the prescribed form a report to the Commissioner for Employee Compensation giving the circumstances attending the death or serious bodily injury.

When an Employee is injured while employed by a contractor, the principal employer is liable to pay compensation to him, but he is entitled to be indemnified by the contractor. The Employee is, however, free to recover compensation either from the principal employer or from the contractor.

Claims for Compensation

The procedure for claiming compensation payable under the Act may be summarized as follows: -

An application for claiming compensation payable under the act has to be made to the Commissioner for Employee's Compensation in the prescribed form.

SHOCK OF UNDERINSURANCE

Insureds who have been insuring for many years tend to sleep over the finer aspects of the updating of insurance cover features. Sudden shock for such insureds can happen when a claim occurs. Static insurance buying can inflict a great toll. Brokers may find it hard to break the routinised ways of insureds on the plea of saving premium. Then comes a disaster owing to which the physical property loss, business interruption loss etc. creates significant losses.

However, during the course of making the claim they discover many hurtful and sobering realities:

- Their reported property values are substantially less than what it will cost to replace the lost property.
- There is the underinsurance clause in their policy that further reduces their potential recovery.

The most common defect in a property insurance cover— usually discovered after the loss—is the insured's failure to update and maintain values that correspond to the costs they are likely to incurred in replacing lost property. At the root of this problem is the fact that most insureds have no real understanding of even the most basic policy terms or definitions.

Understanding Valuation Methods

First, make sure that the insured knows or understands the various valuation methods. Once that is accomplished, they can begin to consider which method that may best suits their insuring needs. Both of these steps must be taken before any decision on values is made. Then the insured should look to their available resources to assist in a correct valuation of properties.

Understanding the underinsurance clause

Basically, the underinsurance clause is the protection gap that happens when the insured under-declares values to state the sum insured, often to save the premium expense or out of sheer ignorance. What most insureds may not appreciate is that the fundamental relationship between policy sum insured and the property value or item wise value of property insured. The result, in effect, is that underreporting values results in insufficient limits, and therefore an underinsurance penalty gets imposed.

There are solutions such as:

1. Report values properly wherever possible with back-up evidence such as purchase papers or valuation of the property insured;
2. Get the underinsurance clause modified so that limited underinsurance gets waived in case of partial losses. In case of total loss, the claim will be limited to the sum insured.
3. The sum insured is a dynamic concept. There can be underinsurance on day one itself. This only happens when an insured is careless. Thereafter there can be further underinsurance as the value of the items insured begins to change owing to inflation and other factors, but the sum insured remains static unless escalation benefit is purchased and escalations are monitored from time to time.
4. The basis of sum insured can be changed to have "agreed value" accepted by the insurer. However, agreed value does not work in many cases.

Possibilities in sum insured and basis of settlement

Coverage	Definition	Where can be used
Actual Cash Value	The cost to repair or replace damaged property; less real depreciation.	Should be considered for buildings that will not be replaced in the event of a total loss. However, the problem of reinstating partial loss remains.
Reinstatement Cost	The cost to repair or replace damaged property with new materials of like kind and quality, or to provide a substitute unit of equivalent utility, without deduction for depreciation.	Appropriate for most properties.
Reproduction Cost	The cost to reproduce damaged property using identical or equivalent materials and techniques, to the extent available.	Should be considered for historic buildings.
Agreed Value	Fixed amount payable in the event of total loss to property.	Appropriate for difficult-to-value items such as fine art.
Selling Price/Market Value	As in the case of finished goods.	Used for valued finished materials

The insured must understand that the sums offered to cover the risks must be based on substantial clarity of correct values.

Types of Underinsurance

- **Ignorant Underinsurance**

  Based on shoddy advice received from insurance advisors or none, consumers may not pay attention to calculating proper value for assets to be insured or renewed. Value fixed for items insured can be revised at any time for property insurance and the insurer will ask for additional premium on pro-rata basis. If the rise in sum insured is not logical or extreme, the insurer can ask for valuation or other evidences to ensure that there is no likelihood of fraud or unexplained claims after the increase in sum insured.

- **Creeping Underinsurance**

  Creeping underinsurance happens when the insured does not pay attention to inflation and any other factor that increases the value of the property insured in a slow manner over a period of time.

- **Overlooked Underinsurance**

  It is possible that the insured or their advisors have overlooked assets or contingencies /needs, that have to be insured.

- **Financier Induced Underinsurance**

  Financiers compel insurance, but often do not pay attention to the sum insured so long as the amount loaned is covered. This makes all claims for partial losses suffer from underinsurance. In total loss cases the insured will not receive full indemnity.

- **Premium saving sum insured**

  When insureds had no loss for many years, they believe that their luck will go on forever. So, they tend to take a chance for another year of underinsurance. This is especially resorted to by organisations that have cash flow problems and various kinds of financial issues. Actually, those who face financial issues, should be careful to insure in full because when a loss happens they will have no wherewithal for recoupment and the banks will be reluctant to finance those who have no or little wherewithal to repay.

How to reduce or avoid Underinsurance?

1. The insured may preferably have the property professionally valued for insurance purposes and after learning valuation and insurance techniques, ensure that sums insureds are suitable adjusted as and when required.
2. The property is better insured, if the insurance is on reinstatement value and not market value.
3. The insured should revalue assets after alteration or renovation of the property.
4. The insured has to ensure that all minor structures like compound walls, outhouses etc. are included in the schedule.
5. There is a need to add costs such as costs of demolition, debris removal and architectural, engineering and municipal costs to the extent required.
6. The stock value is to be properly covered and care is to be taken that fluctuations of stocks values are taken care of by declaration or floater policies as appropriate
7. Inflation costs must be added for capital items, as also the effects of currency changes, customer duties etc. must be smoothened as required.

An office memorandum dated November 29, 2022, by the Department of Financial Services (Ministry of Finance), Government of India ("DFS") has proposed amendments to the Insurance Act, 1938 by way of the Insurance Laws (Amendment) Bill, 2022 (the "Amendment Bill") in order to address the persistent demands of the insurance industry. An important change proposed is an enabling provision for insurers to provide value added services and undertake distribution of financial products. A new clause is proposed to be inserted in the Act to prescribe that "an insurer may also provide services related or incidental to insurance business and may also distribute other financial products as specified by and subject to regulations."

Value Added Services by Insurers

Value-added services are intended to help insurers improve profitability, own the customer interface, and reinvent their product offerings. To capture these benefits, companies must understand the changing needs of customers and brokers and expand new services beyond a core offering.

This can mean that insurers can explore new channels and product offerings to reach potential customers. They may provide high utility value added services which may not be necessarily related to insurance, distribute other financial products (through their wide distribution network) and gain access to prospective customers to whom they can further cross-sell the insurance product. Consequently, a deeper engagement with the existing customers and an opportunity to build a new customer segment will also help in increasing insurance penetration.

As per the current legal and regulatory regime, the insurers are allowed to solely carry on the business of life insurance or general insurance or re-insurance or health insurance.

Insurance companies have been at a disadvantage in contrast to banks and others in the financial sector, as the presence of insurers in the lives of their customers is not frequent and happens only in such times as policy renewal or claims which do not add much to relationships. However, with the advent of technology, insurers can use their repository of data that they may collect from wearables, telematics and other sources, which while improving their decision making, also connect them in value generating ways with their customers. The use of these technologies can help insurers to offer value added services related to their health, lifestyle, or use of vehicles and even asset management.

Value Added Services can be offered in various ways:

Self Service

Customers are offered tools and techniques so that they can manage their risks better. These empowerment techniques offer customers freedom and a way to value-add as per their choices. They can also be offered a menu of coverages, add ons and other benefits in their policies and a combination of covers can get them more discounts as also no-claim discounts, if they utilise their services in risk management that prevents or reduces losses.

Information, Relevant Advice and Assistance

Information that is relevant and non-confusing is a great value add to those who face poverty of time. They need information to make the right choices and hence trustworthy insurers or intermediaries can offer this value. Insurers and Intermediaries can offer to help their customers in preventive management of their risks and also in mitigation of their risks and where applicable, their losses as well. They can offer just-in-times services in a variety of situations.

Collaboration and Engagement

These types of relationships are intended to foster deeper and longer-term relationships that get enriched on the basis of mutual trust as also value-for-money. Optimising economic value on the basis of ready availability and proper pricing of services in a transparent manner encourages the richness of the engagement. In the journey of the insured to betterment in risk management and achieving the desired covers, and having their insurer anticipating their need ahead of time, all help to cement better collaboration on the basis of mutual benefit.

Such value additions can happen in any line of business. For example:

Health Insurance

They can be introduced to health promoting apps that help them or their employees learn about diseases and health conditions, and look at the necessary preventive and curative approaches. Those who are getting treatments can be helped to take their medication in time and also plan their next doctor visit by timely reminders. They can track their body vitals through wearable devices and share their health data with the doctor on a just-in-time basis. Similarly, apps can incentivise healthy behaviour.

Property insurance,

In property insurance there can be partnering with manufacturers to incentivise customers to use sensors to alert them about possible danger or loss. Preventive management can be inbuilt to avoid claims. There can be packages that offer risk management and inspection services in areas such as property insurance, engineering insurance, safety methods to avoid losses through burglary and so on. In the area of cyber insurance, insurers offer the services of cyber security experts who can offer preventive and curative services.

Motor Insurance

Insurers can provide roadside assistance in case of accidents and other emergencies. In vehicle theft cases the assistance of specialised insurance investigators can be invaluable. Survey of vehicles that meet with accidents using IT systems and speeding up the delivery of the vehicle and settlement of claims can be value add to all insureds.

Travel Insurance,

In Travel Insurance, there are innumerable ways in which assistance can be provided such as in managing flight and hotel bookings and planning the journey.

While many of the services are not related to customer risk, they offer insurers an opportunity to engage with the customers in a manner that can tie these customers to the insurers and also provide additional revenue streams.

POLICYHOLDER PROTECTION REDUCED TO A NON-ISSUE NOW

There are scholars who feel that over the last 250 years, insurance law has become insurer biased to the detriment of consumers and modern business. This is one of the reasons why the first line of the IRDAI Act 1999 calls for the "establishment of an Authority to protect the interests of holders of insurance policies...".

Recently the IRDAI issued the Protection of Policyholders' Interests (PPI)... Regulations, 2024 (draft). It simplified and amalgamated various other Regulations into this PPI Regulations. However, in the process all the teeth that were seen in the earlier Regulations appear to have vanished. This is very sad as courts have just begun to use them to penalise insurers. For instance, the NCDRC in the case Nirma Limited vs United India Insurance Co. Ltd. (2022), referred to Sec. 9(6) of the PPI 2017 and ordered 9% interest for the whole claim period, even though the section was for delay in the actual payment.

SALIENT NEGATIVES	
Draft proposed consolidation of 8 different regulation	As a result, the core regulation i.e. Protection of Policyholders' Interests... Regulations, has significantly lost out.
Certain Regulations amalgamated make no sense in the context of protection of policyholders	These include: Places of Business Regulations, 2015, Outsourcing of Activities by Indian Insurers Regulations, 2017, allowing insurers to establish foreign branches, etc...
It was reported in major newspapers that a major proposals is with regards to the free look period of insurance policies - enhance the free look period to 30 days	IRDAI had not cared to enforce the rule that policy wording and clauses should be sent to the insured. It is widely heard that the actual policy wordings are not sent.
Major Provisions in the Regulation of 2017 not found now:	
Chapter 6 is on settlement of claims	Amalgamated the three different section in the earlier PPI – Life, Health and General
	Not a word about the surveyor appointment, timelines, and interest for delay.
	Just 17 lines of very generic and watered down words.

The Grievance Redressal Procedure as specified shall be followed scrupulously by all insurers and distribution channels.	Not a word on the timelines or penalties
Even under the earlier regulation many issues addressed were never taken forward.	Insurers were to give a copy of the proposal to the insured within 30 days. This is not done.

The Big Press Hailed the Regulation

The public relations of the Regulator got everyone in the press to praise the new regulations as earthshaking. One said: Irdai draft guidelines to safeguard insurance policyholder interests: 5 major changes proposed. Another said: "Enhancing the protection of insurance policyholders…." Many such applause were seen. In the olden days the press, who were vocal about the policyholder would critically look at the regulation and offer their comments soberly. This was not seen at all.

What IRDAI had done in the past

It had come out with a Regulation as early as 2002, which was among the earliest Regulations. Subsequently from time to time many advisories and circulars were issued to protect the policyholder. In 2017 a revised Regulation came out which was much better and gave confidence to the customer. The IRDAI even published a Handbook on grievance redressal., which is available even on the website of the National Centre for Financial Education (NCFE). However, none of the minimum turnaround times have been shown in the Regulations.

What IRDAI had not done

Courts have from time to time give their critical comments on the service of insurers and stricture them. Most of the time the Regulator took no notice, not even a show cause to the insurer. There were many court rulings even at the Supreme Court on compelling insureds to accept unfair settlements by the use of the 'full and final' voucher technique. Finally, the Delhi High Court in the case in the case Worldfa Exports Pvt. Ltd. vs United India Insurance Co. Ltd. (2015), that "issued notice to IRDA with respect to unfair trade practice being indulged into by the insurance companies despite the numerous judicial pronouncements". Then only IRDAI issued a circular dated 24.09.2015 directing insurers "not to use the discharge vouchers as a means of estoppel against the insured to seek higher compensation" (court words). These stipulations are not seen in any PPI Regulation, and cannot be expected in the new pygmy toothless one.

Contrast with other Regulators

On 01/05/2020, the FCA (UK) announced formally that it intended to obtain a court declaration to resolve contractual uncertainty in business interruption (BI) insurance cover as "public interest to advance our consumer protection and market integrity objectives." The FCA specifically stated that they "expect all general insurance (GI) firms to meet their obligations under Principle 6, ICOBS and DISP when handling claims and any complaints arising from them, and to communicate clearly and sympathetically to their customers at all times." Also, that "In some cases where there is no cover provided under the policy, there is a gap between firms' and customers' understanding of what they thought was covered by the policy. If the BI cover provided is not consistent with what the customer requested or instructed, or with what the customer was informed was being provided, then customers may raise these concerns as a complaint with their insurer or intermediary."

Instead of going miles forward as other Regulators are doing the Regulator here appears to be going backward.

SUM INSURED ADEQUACY IN PROJECT INSURANCE

Calculation of the Sum Insured – Policy Terms

Memo 1. SUM INSURED – in the EAR and CAR Policy states:

"It is a requirement of this insurance that the Sum of Insurance stated in the Schedule shall not be less than the completely erected value of the property inclusive of freights, customs duty, erection cost and the Insured undertakes to increase or decrease the amount of insurance in the event of any material fluctuation in the level of wages or prices. Provided always that such increase or decrease shall take effect only after the same has been recorded on the Policy by the Company.

If, in the event of the occurrence of a loss, or damage it is found that the Sum Insured representing the completely erected value of the property and/or of particular items involved is less than the amount required to be insured the amount recoverable by the Insured under the Policy shall be reduced in such proportion as the Sum Insured bears to the amount required to be insured."

Memo 2 - PREMIUM ADJUSTMENT – Clause States

The Sum Insured under the Policy representing the complete value of the contract works shall be adjustable at completion of the construction on the basis of actual values to be declared by the insured in respect of freight and handling charges, customs dues and construction cost and difference in premium shall be met with by payment at the rate agreed to or by the insured as the case may be. Any increase or decrease in the Prime cost of materials shall not be the subject matter of premium adjustment.

Memo 3 - REINSTATEMENT OF SUM INSURED – states:

In the event of loss or damage the Insurance shall notwithstanding be maintained in force during the period of insurance for the Sum Insured the Insured undertaking to pay a pro-rata additional premium on the full amount of each claim for the loss or damage from the date of such loss to the expiry of the period of Insurance.

Memo 4 - BASIS OF LOSS SETTLEMENT – states:

In the event of any loss or damage the basis of any settlement under this Policy shall be - a) in the case of damage which can be repaired the cost of repairs necessary to restore the property to their condition immediately before the occurrence of the damage less salvage, or b) in the case of a total loss - the actual value of the property immediately before the occurrence of the loss less salvage; however, only to the extent the cost claimed has to be borne by the Insured and to the extent they are included in the Sum Insured and provided always that the provisions and conditions have been complied with.

All damages, which can be repaired, shall be repaired, but if the cost of repairing any damage equals or exceeds the value of the property immediately before the occurrence of the damage, the settlement shall be made on the basis provided for in (b) above.

The cost of any provisional repairs will be borne by the Company if such repairs constitute part of the final repairs and do not increase the total repair expenses. The cost of any alterations, additions and/or improvements shall not be recoverable under this Policy.

Practice of Setting the Sum Insured

For a CAR/EAR policy, the general practice or rule is that the Sum Insured will represent the amount (or "price") that the principal will pay to the Contractor(s) executing the Project. Where there is separate design or construction related consultancy contracts awarded, then the costs of the same should also be included within the declared amount. However, there are often various other costs incurred by the principal (such as land acquisition and financing costs) that may be considered as "non-recurring" costs and therefore not a strict part of the project and having claims for repair, replacement or reinstatement

Courts have commented on the sum insured adequacy. In the case The Dominion of Canada General Insurance Company v. Viking Fire Protection Inc., 2019 NLCA 13, the Court of Appeal of Newfoundland and Labrador stated, referring to the various cases decided by the Canadian Supreme Court: "[40] If there is damage or loss to property related to the project, in the course of construction, the Builders' Risk policy responds to that loss, thereby allowing the project to carry on. In this way, the insurance furnishes "funds to rebuild" any lost work (Commonwealth Construction at 328), and to replace any new property incorporated into the project which was damaged or destroyed during the construction process. By so doing it "provides protection against the crippling cost of starting afresh in such an event" (again see Commonwealth Construction at 328). This recognizes the shared interest of the owner, contractor, and various subcontractors in getting the project completed.

As a result, a project need not be unduly set back or abandoned altogether due to lack of funds to rebuild that which had been built, but which was subsequently damaged or destroyed before the project was completed. The availability of insurance funds arising from Builders' Risk coverage thereby benefits the contractors and tradespersons working on the project, as well as the project's owner.

In the same case with regard to the sum insured the court said: " I would not view as coincidental the fact that the contract price and the Builders' Risk insurance coverage are approximately the same. Rather than a coincidence, it would be reasonable to conclude that the $688,961 insurance policy limit was chosen purposefully. The $688,961 limit, one might rationally conclude, was meant to reflect the parties' reasonable expectations that sufficient insurance be obtained to protect against a loss, including a loss up to the full value of the work being done in the project, but no more than that amount. This is consistent with the underlying function of Builders' Risk insurance, discussed earlier."

The court also said " A contractual requirement, as in the present case, that the amount of insurance be just marginally greater than the contract price (i.e. 1.1 times the contract price) achieves this, and ensures adequate insurance funds exist to complete the project.

No Coverage for Pre-existing Property

Conversely, this $688,961 insurance policy amount has no correlation whatsoever to potential loss or damage to pre-existing property at the hospital complex. This again suggests that the parties' reasonable expectations were that damage or loss to pre-existing property would not be covered under the Builders' Risk policy.

The court did not agree to the lower court view that such damage is covered.

"In my view, this does not take into account the parties' intentions in setting the amount of insurance coverage required for the project at $688,961. This is because, if all pre-existing property in the hospital complex was intended to be insured, the $688,961 coverage under the Builders' Risk policy is clearly inadequate. As a consequence, the property would be grossly underinsured.

This conclusion, that the risk is underinsured, is unsatisfactory in that it would be inconsistent with the parties' reasonable expectations. Presumably the parties to an insurance contract, if their intentions were to insure all pre-existing property at a multi-million-dollar hospital complex, would not be content to knowingly obtain inadequate insurance in the amount of $688,961."

Additional Amounts as stipulated can be covered

Some forms of contract conditions require the CAR/EAR insurance Sum Insured to represent the contract amount plus an additional allowance for debris removal and Professional Fees (typically 5-10% of contract amount). In some other cases there are also materials or equipment that may be provided by the principal and, unless already included in the Sum Insured, these are typically known as "free issue materials". An amount representing the replacement cost of such material or equipment should therefore be added to the Sum Insured. The importance of all of this is because the policy premium is ultimately calculated and adjustable on the contract sum or "price".

There are of course a number of variables that should also be considered when initially agreeing upon a Sum Insured and perhaps the most relevant of these are as follows: -

Factoring- in Inflation

Longer period contracts very often have an agreed sum at inception but with allowances for inflationary increases based upon various indices. In such circumstances it is perhaps usual for the Sum Insured to represent the agreed amount at inception and then the final sum as declared at the completion of the contract would include the application of such inflationary increases during the contract period.

Taxes and Duties

Taxes and particularly GST (or its equivalent) should also be considered when setting the Sum Insured. Typically, the insured would be able to recover the GST from the Government and therefore not include an allowance for it in the Sum Insured. In the event of a claim insurers would not expect to pay GST if it was not included in the Sum Insured and therefore premium computation – and of course the insured should not be in a position to recover taxes both from insurers and the Government.

Cost of Contingencies

Many contract amounts contain significant sums for "contingents". These can include such things as measures to overcome unexpected ground conditions, variations in cost of labour, material, fuel etc. and any number of other unknowns or possible variables that may significantly impact the actual final cost of construction. It is debatable whether these "contingents" should be included in the Sum Insured at inception or simply added during the course of the project when actually incurred, or simply declared as part of the final contract sum/price upon completion of the project. In extreme examples, the "contingents" amount can represent over 30% of the provisionally estimated total contract sum at project commencement.

Issues relating to debris removal, expediting expenses etc

Under many policy wordings such things as debris removal, expediting expenses etc. are payable in addition to the Sum Insured whereas in others they are included within the Sum Insured. The basis of policy indemnity in this respect needs to be considered by both the insured and the insurers/reinsurers when setting the Sum Insured and calculating the premium respectively.

It is appropriate to note that the policy premium is normally arrived at by applying the agreed rate to what is normally referred to as "final contract price", the provisionally estimated figure being used for calculation of the deposit premium and then with the insured declaring the actual final contract price upon project completion.

A Broad of Business Interruption insurance

Business Interruption (BI) cover is taken so as to protect a business against the consequential financial losses following a covered damage to property. Most BI policies, require that the damage to the property has to be covered under a property damage policy as a pre-condition to indemnity. Thus, a standard BI cover would be more accurately described as "Property Damage Consequential Loss Insurance."

However, the basic BI cover can be expanded by a number of extensions, so as to provide cover in specific wider circumstances. Where the extensions are of wider benefit they may include 'non-damage-based' extensions covering some other common situations which can cause an interruption to an insured's business in the absence of property damage.

First of all, it is possible that little is required by way of damage. The classic example of this is the case where damage was found to be the sub-molecular changes in the pastel of a famous painting La Danse Grecque, a Degas pastel, affected by a fire (even though the pastel itself did not sustain direct fire or smoke damage) while it was stored in a strongroom at an auctioneer's. There was a chance that the pastel would decay sooner than it otherwise would have, thus reducing the sale value. The Court held that sub-molecular changes were damage. This was decided in the case Quorum v Schramm [2002] 1 Lloyd's Rep 249.

The court ruled as follows: "(3) The task of the court in valuing a work of art of the quality and value of the pastel was to ascertain the price that could be achieved between a willing seller and a willing buyer within a reasonable period of time in the relevant market: if there was an open market price, that should be ascertained. The court should take into account all the evidence available, including evidence of prices obtained at auctions. Where there were two distinct markets, as in the instant case, the court should take the value in the market actually used, or, if neither had yet been used, the value in the higher of them. Applying those principles to the evidence, the value immediately preceding the fire was $US3·6m, and the value after it was $US2·2m. Accordingly, the sum of $US1·4m was recoverable under the insurance policy."

Covid and BI Policy

The impact on the business of small and medium enterprises from Covid-19 pandemic and lockdown were obvious. Many companies applied for indemnity under Business Interruption (BI) insurance policies. In the UK it was reported that the policy language apparently covered business interruption resulting from Covid-19, but BI insurers are refusing to pay. The Financial Conduct Authority ("FCA"), of UK decided to go to court in support of those whose BI claims were rejected for claim under the government lockdown during Covid.

The Supreme Court has handed down judgment in the case FCA v Arch Insurance (UK) Ltd and others [2021] UKSC 1, more commonly known as the 'FCA Test Case'. The FCA Test Case was brought by the Financial Conduct Authority on behalf of policyholders under the Financial Markets Test Case Scheme in order to determine whether certain non-damage clauses commonly used in business interruption property insurance policies would cover losses caused by the cessation of business due to the COVID-19 pandemic.

There were six issues that the Supreme Court considered:

- The interpretation of "disease clauses," being clauses which relate to business interruption losses on the occurrence of a notifiable disease within a specified distance of the insured premises.
- The interpretation of "prevention of access clauses" and "hybrid clauses." Prevention of access clauses typically concern those situations where business interruption occurs because the insured is unable to access their business premises due to restrictions imposed by a public authority. Hybrid clauses contain both disease and prevention of access elements.
- The nature and extent of any causal link that must be shown between the business interruption and the relevant event (in this case, the occurrence of the COVID-19 pandemic and public health measures put in place to mitigate the impact of the disease).
- The effect of "trends clauses" which are used to determine the effect of business interruption on the business by considering previous or regular trading patterns.
- The significance of quantifying losses on the basis of trading patterns before the insured event ("pre-trigger losses").
- The status of the decision in Orient-Express Hotels Ltd v Assicurazioni Generali SpA [2010] EWHC 1186 (Comm) which concerned causation and the interpretation of trends clauses.

The court found as follows:

Disease clauses

The SC did not agree with the first instance decision that disease clauses cover business interruption losses resulting from COVID-19 wherever there has been an occurrence within the relevant geographical radius. Instead, the Supreme Court found that each illness sustained is a separate occurrence and that disease clauses only cover cases within the relevant radius.

Prevention of access/hybrid clauses

The lower court at first instance held that prevention of access clauses can only be satisfied by a measure expressed in mandatory terms which has force of law. The Supreme Court rejected this view as too narrow deciding that an instruction by a public authority that restricts access to premises will amount to a "restriction imposed" if it carries the imminent threat of legal compulsion or is in mandatory and clear terms and indicates that compliance is required without recourse to legal power. Where a policy covers the "inability to use" premises, this cannot cover mere hindrance. Nevertheless, this term will cover those situations where there is an inability to access a discrete part of the premises and will cover a discrete activity that cannot be undertaken.

Causation

The Supreme Court held that all individual cases of COVID-19 that had occurred by the date of UK Government measures put into place were equally effective proximate causes of loss. Accordingly, policyholders need only establish that there was at least one case of COVID-19 within the relevant geographical area set out in the policy. The Supreme Court rejected insurers' argument that one event cannot in law be a cause of another unless it can be said that the second event would not have occurred in the absence of ("but for") the first. The insurers essentially arguing that it was necessary for the individual occurrence of COVID-19 within the relevant area be the effective cause of loss.

rather than the wider Government measures. The Supreme Court instead held that the "but for" test was not an essential test of causation and can sometimes be inadequate in situations (such as those in this case) where a series of events all cause a result.

Trends clauses and pre-trigger losses

The Supreme Court held that these clauses should not be construed with the effect that they take away cover provided by the insuring clauses. The trends for which clauses require adjustment do not include circumstances arising out of the same underlying or originating cause as the insured peril (in other words you cannot apply the underlying trend of the COVID-19 pandemic to reduce coverage for claims resulting from that same event). Adjustments can, however, be made to reflect circumstances unconnected to the pandemic.

The Orient-Express Case

As a result of the decision in respect of trends clauses and causation, the Supreme Court ruled that the case Orient-Express Hotels Ltd v Assicurazioni Generali SpA [2010] EWHC 1186 (Comm) was wrongly decided, by the court concerned.

How do Courts interpret the term 'Consequential Loss'

The England and Wales High Court (Commercial Court) in the case Ferryways NV v Associated British Ports [2008] EWHC 225 (Comm) explained the term as follows: "81. The words "consequential" or "indirect or consequential" when used in an exemption clause have been construed in a number of different contexts. In Deepak the clause in question stated that the supplier of certain technology and know-how for the construction of a methanol plant was not liable for "indirect or consequential damage." The Court of Appeal appear to have held that such phrase only excluded losses which were other than the direct and natural result of the breach; see [1999] 1 Lloyds Rep 387 at p.403. The Court of Appeal considered itself bound by the decision of the Court of Appeal in an earlier case, Croudace v Cawoods [1978] 2 Lloyds Rep. 55, which concerned the liability of a supplier of masonry blocks required for the construction of a school and where the phrase "consequential loss or damage" was held not to cover any loss which directly and naturally results in the ordinary course of events from the breach. In Croudace the Court of Appeal had considered that the ratio decidendi of an earlier case in the Court of Appeal, Millars Machinery v David Way (1934) 40 Com.Cas 204 (which concerned the liability of the manufacturer of gravel washing plant for consequential loss), was binding on it. Mention should also be made of Saint Line v Richardsons [1940] 2 KB 99, a decision of Atkinson J. concerning the ambit of a clause which protected an engine builder from "indirect or consequential damages". Atkinson J. held that the decision in Millar's Machinery provided guidance and that the words "indirect or consequential" do not exclude liability for damages which are the direct and natural result of the breaches complained of."

In the case Deepak Fertilisers & Petrochemical Corporation v Davy McKee (London) Ltd & Anor [1998] EWCA Civ 1753 referred above, which dealt with a construction claim, the

England and Wales Court of Appeal (Civil Division) examined the issue of consequential loss. The court stated: "89. On behalf of Deepak, it is said that the Learned Judge fell into error in so deciding. In relation to causes of action falling within Article 6.8 it excludes liability for (i) loss of anticipated profits, (ii) loss of catalyst, (iii) loss of raw-material, (iv) loss of products, and (v) indirect or consequential damages. The heads of claim are in respect of fixed costs and overheads referable solely to the methanol plant during the period from the explosion to the resumption of commercial production, and loss arising from the fact that the reconstructed plant used more catalyst per charge than the original, respectively. It is said that neither head of claim falls within any of (i)-(v). In particular, as regards (v), "indirect or consequential damages" are losses other than direct loss naturally arising from the breach of contract or duty under consideration, and neither of the heads of claim at issue arose other than directly and naturally from the breaches of contract or duty alleged. Davy submit that these claims are excluded under the language of "indirect or consequential" damages, or in the case of the last head of claim under the word "catalyst". Croudace Construction Limited v Cawoods Concrete Products Limited [1978] 2 Lloyds Rep. 55 concerned the late delivery of masonry blocks which the buyers required for the construction of a school. The contract of sale provided that the sellers were: "Not under any circumstances to be liable for any consequential loss or damage caused or arising by reason of late supply ...."

The court held that the word "consequential" did not cover any loss which directly and naturally resulted in the ordinary course of events from late delivery. He held that losses which began to "clock up at once," (namely the cost of idle men and plant etc.) were to be regarded as direct and not consequential. His decision and reasoning were upheld by the Court of Appeal. The Learned Judge having considered this decision stated that he did not find the citation of much assistance in determining the application of Article 6.8 to the individual heads of damage and to their constituents. He continued: "In this contract it seems to me that the direct loss contemplated was the cost of getting the plant right, not the indirect or consequential losses flowing from getting the plant wrong." He accordingly rejected the claim for fixed costs and overheads.

90. We are unable to accept that conclusion. The direct and natural result of the destruction of the plant was that Deepak was left without a Methanol plant, the reconstruction of which would cost money and take time, losing for Deepak any methanol production in the meantime. Wasted overheads incurred during the reconstruction of the plant, as well as profits lost during that period, are no more remote as losses than the cost of reconstruction. Lost profits cannot be recovered because they are excluded in terms, not because they are too remote. We consider that this Court is bound by the decision in Croudace where a similar loss was not excluded by a similar exclusion and considered to be direct loss. Accordingly, we cannot agree with the Learned Judge's conclusion: "In essence, therefore, loss of profits and overhead expenses thrown away are too closely related elements of the consequential loss which flows from a break in production." We have come to the conclusion that this was an error in law and that the finding of the Judge on this issue must be reversed.

91. We find the extra catalyst cost more difficult. The Learned Judge said: "As to the extra Catalyst claim, I think that in the absence of any guarantee concerning Catalyst, that is also covered by the exclusion of indirect or consequential damages, even if it be not within 'catalyst'."

92. On behalf of Davy, Mr Wilmot-Smith contends that it must be appropriate to exclude the consequential losses regardless of the source

of liability such losses, being, as a matter of construction all the losses claimed save for the cost of reconstructing the plant.The approach to the clause in separating out such losses as being the cost of "getting the plant wrong", as opposed to the cost of putting the plant right, is he submits an appropriate one. In our view, just as the Judge's distinction between the "cost of getting the plant right" and loss suffered as a result of Davy's "getting the plant wrong" lead him into error in regard to the claim for wasted overheads (and loss of profits) he has mistakenly applied the same reasoning to the extra catalyst cost. In our opinion, the extra cost claimed is not (as contended by Mr Wilmot-Smith) 'a loss of profit claim by another name'. The extra cost claimed is the cost which has now become necessary in order to ensure and enable the plant safely to produce the methanol in those quantities which the plant was supposed to. In other words, we would hold that this extra cost is akin to any other cost (such as an additional piece of plant or part) which achieved the same result. This could not be categorised as an indirect or consequential loss or damage nor could its cost be categorised as constituting a loss of profit. Accordingly, we would reverse the Learned Judge's conclusion on this aspect also."

In the case Star Polaris LLC v HHIC-Phil Inc [2016] EWHC, England and Wales High Court (Commercial Court) quoted: Chitty on Contracts (31st Ed.) summarizes the position as follows at para 15-009: "The exclusion of liability for "consequential loss or damage" will not cover loss which directly and naturally results in the ordinary course of events from the breach, but only loss which is less direct or more remote."

The United States District Court for the Eastern District of Pennsylvania in the case Jay Jala, LLC v. DDG Constr., Inc., 15-3948 (E.D. Pa. Nov. 1, 2016), stated: "Rather than turning on foreseeability, the difference between direct and consequential damages depends on whether the damages represent (1) a loss in value of the other party's performance, in which case the damages are direct, or (2) collateral losses following the breach, in which case the damages are consequential." Atl. City Associates, LLC, v. Carter & Burgess Consultants, Inc., 453 F. App'x 174, 179 (3d Cir. 2011). "Direct damages refer to those which the party lost from the contract itself —in other words, the benefit of the bargain— while consequential damages refer to economic harm beyond the immediate scope of the contract." Id. (quoting Penncro Assocs., Inc. v. Sprint Spectrum, L.P., 499 F.3d 1151, 1156 (10th Cir. 2007)).

In Canada, the Supreme Court of Canada in the case Ledcor Construction Ltd. v. Northbridge Indemnity Insurance Co., 2016 SCC 37, [2016] 2 S.C.R. 23 explained the term: "[57] Bearing the above-mentioned principle in mind, the Policy in this case contains exclusions that do not pertain to "physical loss or damage" otherwise covered under clause 2. For instance, clause 4(A)(a) of the Policy excludes from coverage "[a]ny loss of use or occupancy or consequential loss of any nature howsoever caused including penalties for non-completion of or delay in completion of contract or non-compliance with contract conditions". This exclusion deals with a form of pure economic loss stemming from contractual breach, not physical loss or damage. Additionally, clause 28 of the "standard conditions" section excludes "costs, fines, penalties or expenses" imposed by governments under environmental legislation. This also does not relate to the Policy's base coverage for physical loss or damage."

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