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EDITORIAL

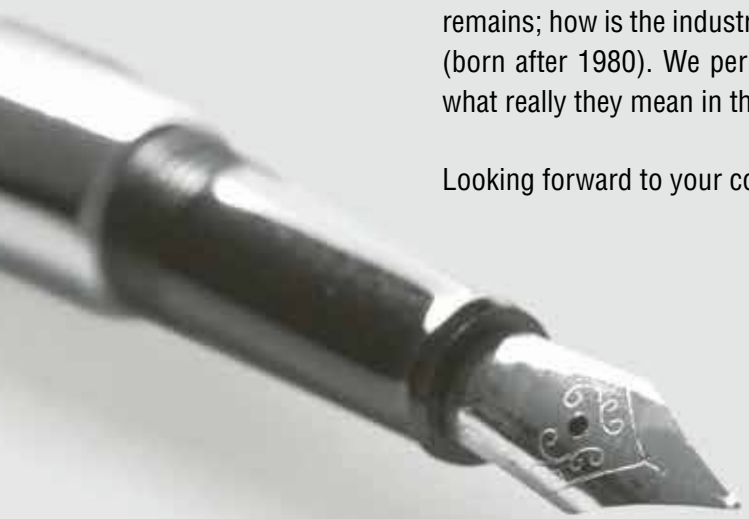
The October issue of the journal brings you a set of prize winning articles which were presented for the Insurance Institute of India's various awards. Every year the institute offers awards for the best technical papers received in the five areas of life, general, health, micro insurance and pensions. In addition there are two awards given to winners of the S. K. Desai Memorial Essay Writing Competition and D. Subramaniam Award Essay Writing Competition. The award winning papers are normally published in the October – December issue.

This year we are happy to note some new ideas have come up before us – like the paper on workplace spirituality and the comprehensive analysis on the insurance ombudsman system in India, to name a few. We hope all these articles will engage your mind and inspire you to consider themes on which to do innovative and cutting edge research.

The next issue of the journal would be thematic. The theme is **'Service Excellence in Insurance'**. In an era when attracting and retaining customer has become one of the principle challenges faced by the industry, the concept of service and customer relationships would need to be reexamined and perhaps, predefined. We would like to receive articles/papers which explore new perspectives in the field and open up new dimensions of service and relationship excellence.

In recent years a number of themes have emerged, like customer life time value, analytics and big data, marketing in the digital age…The challenge remains; how is the industry going to excite and keep the millennial customer (born after 1980). We perhaps need to go beyond buzz words and explore what really they mean in the context of today's customer and industry.

Looking forward to your contributions.



Merit Winner

S.K. Desai Memorial Essay Writing Competition

Workplace Spirituality– An Effective HRM Strategy for Indian Insurance Industry

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Abstract

The popularity of the concept of spirituality is increasing exponentially in the field of Human Resource Management. Both academicians and practitioners are looking at spirituality to solve modern day human resource challenges. Indian insurance industry is facing some serious HR related challenges. The present paper tends to explore the impact of work place spirituality on three specific HR issues of Indian insurance companies. These three HR challenges are employee engagement, work motivation and managerial effectiveness. Spirituality at work is about the search for meaning or higher purpose, connectedness and transcendence. The present research paper also addresses the conceptual and empirical gaps in using the concept of workplace spirituality and empirically examines relationship between workplace spirituality and employee engagement, work motivation and managerial effectiveness. The paper successfully augments literature by suggesting one more dimension (Karma Capital) of Indian spiritual values. This is one of the pioneer studies that used Necessary Condition Analysis (NCA) to explore workplace spirituality.

Workplace spirituality was reported as a necessary determinant of employee engagement, motivation and managerial effectiveness. The relationship between these variables is further investigated through correlation matrix and regression analysis.

Introduction

There has been an exceptional expansion in the service industries (Bateson and Hoffman 1999) and Indian insurance industry has also seen remarkable growth and penetration in recent time. It is a well accepted and established fact that the service sector is a human resource intensive industry. In this era of throat-cut competition in the insurance sector, only human resources can act as a potential source of competitive advantage. Hence, insurance companies have started to put greater emphasis on human resource management practices. A strategy that focuses on the human side can be an effective way for ensuring success in the current competitive global business environment (Verma 2000). A well-defined and established structure of high performance work practices benefits not only the organization but also the employee. HR policies of an association benefit the employee by providing better opportunities for growth in terms of better compensation, benefits, training and development opportunities, and career management, in turn leading to job satisfaction and self-fulfillment. Both academicians and practitioners have concluded significant and far reaching changes in Indian insurance sector. The penetration and reach of insurance products have reached every nook and corner of Indian society. The insurance industry has become one of the fastest growing service industries of India. Insurance companies have witnessed exponential growth in recent years and it has resulted in increased insurance density and penetration. A report by IRDAI highlighted the golden prospects of higher growth and prosperity owing to huge untapped market (especially smaller cities and rural areas), arrivals of new products, de-tariffing of insurance premium, growth in private and foreign investment, and also due to increase in government schemes and support. The insurance sector is expected to have a consistent growth rate of about 10 to15% in the next five years or so. Madhavi (2014) reported major challenges on the path of accelerated growth of the insurance industry. The most challenging hurdles are related to the human aspect ranging from attrition, lower morale, high organizational role stress, lower employee engagement level and lower levels of mutual trust and respect.

Liberalization in the Indian insurance sector has opened the sector to private competition. A number of foreign insurance companies have set up representative offices in India and have also tied up with various asset management companies (Shanker 2006). All these developments have forced the insurance companies to be competitive. Under present market forces and strict competition, the insurance companies are forced to be competitive. Contemporary companies must seek ways to become more efficient, productive, flexible and innovative, under constant pressure to improve results (Kundu and Malhan, 2009). The traditional ways of gaining competitive advantage have to be supplemented with organizational capability and the firm's ability to manage people (Ulrich and Lake, 1990). What makes a firm best is not just technology, bright ideas, masterly strategy or the use of tools, but also the fact that the best firms are better organized to meet the needs of their people, to attract better people who are more motivated to do a superior job (Waterman, 1994).

With constant internal and external pressures, HR of insurance industry needs to constantly respond to such changes and needs to build suitable models and strategies to cope up for effective management. Internal pressures may include infrastructure, workforce planning and management, cost management, globalization of workforce, training and development. External pressures can be changes in government regulation, changes in market conditions, changing employee and customer demographics. Other challenges may include, difficulty in retention management, managing workforce diversity, rising training and replacement costs, increasing turnover rate and talent crunch. Among the greatest challenges faced by HR is employee engagement. Rising attrition and switching of employees from one firm to another poses a serious challenge to top management of insurance companies. Another of its most challenging issues is motivation and morale of employees of insurance companies. Motivation is the key to higher levels of productivity and profitability. But Indian insurance companies are reeling badly under relentless heat of poor level of work motivation. These challenges check their ability to adapt to changing business environment, improve work efficiency and capitalize on growth in the sector. HR needs to analyze, innovate and reconstruct existing policies in order to keep up with the frequent changes. With rapid, unpredictable and profound transformation underway in insurance industry, the issues HR must face have

increased multiple folds and calls for rapid involvement. There is a need for creating new models and strategies, to adapt and evolve to such changes by the HR.

Benefit of HR Practices

HPWS is believed to have positive effects on employee attitudes, motivation, trust and well-being, in addition to their favorable effect on organizational gains (Ogbonnaya, Daniels, Connolly and van Veldhoven, 2013). Where an HPWS is designed by organizing individual human resource (HR) practices in a coherent fashion, then they elicit favorable persuasion over organizational performance through corresponding positive impacts on employee attitudes, motivation and well-being (Sun et al., 2007; Boxall et al., 2011; Van De Voorde et al., 2012). Scholars have established positive association between HPWS and job satisfaction (Barling et al., 2003; Gould-Williams, 2003), organizational citizenship behaviors (Sun et al., 2007), Job satisfaction (Takeuchi et al., 2009, Harley et al., 2007), workers' faith in management (Gould-Williams, 2003) and affective commitment (Harley et al., 2007, Takeuchi et al., 2009, Boxall et al., 2011). As higher levels of employee satisfaction, trust and commitment will increase employees' loyalty and probability to remain with the firm, employee turnover rates are reduced and consequently it promotes organizational productivity.

Ability Motivation Opportunity (AMO) model of human resource management can explain the employee related outcome of HPWPs (Appelbaum et al., 2000; Macky and Boxall, 2007; Boxall and Macky, 2009; Jiang et al., 2012). AMO model defines three different ways through which HPWS influences employee. Firstly, complementary HPWPs like training & development, career progression plan, job enlargement, succession planning etc. enhances employees skill, expertise and ability. More competent and skilled employees can perform their job tasks more efficiently and show initiative at work. Secondly, Other HPWPs like management by objective, decentralized decision making, fair and equitable pay, social security scheme etc. motivates employee to perform better. Motivated employees could utilize their skills and competencies in more efficient and effective way. Thirdly, practices like succession planning, decentralization, autonomous and creative team etc. provides opportunities for employees to maximize their potential through dynamic involvement in workplace activities. These opportunities give employees a chance to articulate their creative and managerial competency in such a way that it enhances their experience of meaningfulness at work.

Workplace spirituality has evolved in recent times as a High Performance Work System. Both academicians and practitioners are relying on spirituality to crack modern day human resource challenges like engagement, motivation, stress, attrition, corruption etc. Modernization has drastically changed the work style and work relationship in modern organizations. Latest technology and techniques has transformed the work culture and organizational climate. All these transformations and developments have changed the equilibrium of association between employees, organization and society. Growing materialism and blind race for profit and wealth maximization has disturbed mutually beneficial relations between these three pillars of a nation. But it is important to know that in the midst of all these developments and transformation, spirituality has its own role to play. Spirituality benefits nation at all three levels, the societal level, organizational level, and the individual or employee level (Moore and Casper, 2006). Insurance industry can also explore utility of workplace spirituality to resolve its issues related to Human Resource Management.

Workplace Spirituality- A New Era of Effective HRM

The popularity of concept of spirituality is increasing exponentially in the field of Human Resource Management (English, Fenwick and Parsons, 2003). Spirituality at work place has lead to greater level of social responsibility by growing number of organizations (Miller, 2001). Jurkiewicz and Giacalone, (2004) reported that spirituality is associated with higher level of organizational efficiencies and rate of return. Krahnke (2003) stated that spirituality leads to increased physical and mental health of employees. It also results into advanced personal growth and enhanced sense of self worth. Workplace spirituality helps employees to optimize their performance potential (Mitroff and Denton, 1999). Mohamed et al. (2004) assert that the spirituality makes an employee more tolerant for work failure and less susceptible to stress. Scholars have started to explore motivational aspect of workplace spirituality in recent times. Various studies have observed a 'U' shaped graph between employee's motivation to excel, desire to utilize their maximum potential with employees stay with the firm (Yadav and Yadav, 2016). Increasing numbers of organizations are looking for different ways to motivate their work force while modern day employees are searching for meaning and the desire to experience spirituality at work (Kumar and Neck 2002; Hill

and Smith 2010). Employees' desire for spiritual workplace is governed by their pursuit to increase their work productivity. Even though both issues are connected with the spirit at work but research exploration on both i.e. workplace spirituality and employee motivation has developed independently. Studies have hardly tried to understand the interconnectedness between work place spirituality and motivation level of employees. Ming-Chia (2012) observed that very few studies are available in this field. There could be a number of reasons for less interest of authors in this area. Firstly, spirituality is seen as individual and private affair in India and workplace spirituality is not widely practiced in Indian organizations. Secondly, owing to availability of numerous religions, sects and lines of faith, scholars are not unanimous about definition of term spirituality and for its constructs. Thirdly, quantification of spiritual values and spirituality possess another challenges for scholars. Finally, Indian spiritual values (eg. contentment with what we have) and work motivations/employee engagement are seen as totally opposite paradigm. Thus association between them has not been systematically and convincingly investigated in Indian settings. The present study is one of the pioneer works in this field that makes use of Necessary Condition Analysis to arrive at a convincing result. The present paper also tries to augment available literature on spirituality and its constructs through adding knowledge from Indian spiritual epics-Bhagawad Gita, Astavakra Gita and Kena Upanisad.

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Literature Review

Defining Workplace Spirituality

Workplace spirituality has been defined in number of ways- as intelligence, developmental line, attitude, value and belief system, way to connect with inner/super power and inner experience. Zohar and Marshall (2000) defined spirituality in terms of intelligence. According to Zohar and Marshall (2000), spirituality is referred to hyper thinking, meaning giving, contextualizing and transformative intelligence. Thus spirituality gives way to intelligence Quotient (IQ) and also to Emotional Quotient (EQ). Spirituality could also be seen as capacity to transcend the physical and material world (Emmons, 2000). Spirituality also includes the ability to experience heightened states of consciousness. Wilber (2004) asserted that the spirituality depicts highest level of any developmental line. For example, spirituality indicated trans-rationality when one considers cognition as a developmental line. Kumar and Neck (2002) described that workplace spirituality includes a search for meaning and fulfillment and it is also related to feeling of being interconnected with one's work and with others also. Mitroff and Denton (1999) asserted that spirituality could be defined as ability to get connected with one's complete self as well as with others and the universe. The authors elaborated that the concept of interconnectedness best depicts the meaning of spirituality. Other authors have defined spirituality with different connotation (eg. inner experiences (Dillard 1982), attitude of openness and care (Miller2004), morality (Kohlberg and Ryncarz1990), faith (Fowler 1981), and work place integration, connectedness (Ingersoll 2004), compassion (McCormick 1994), respect, shumility and courage (Heaton et al. 2004), common purpose (Kinjerski and Skrypnek 2004), inclusiveness and interconnectedness (Marcqus et al. 2005) and so on). Case and Gosling (2010) has rightly concluded that the concept of spirituality is plagued by problems of definition. As there is little consensus over meaning and definition of spirituality, thus is has been associated with some key dimensions or constructs (McKee et al., 2008).

Dimensions/Constructs of Workplace Spirituality

Further, different constructs have been highlighted in different studies. Milliman et al. (2003) identified three constructs of workplace spirituality. These three dimensions of workplace spirituality are meaningful work, alignment with organizational values and community. Ashmos and Duchon (2000) also identified dimensions of spirituality i.e. meaning, purpose, and a sense of community and connection to others. Other scholars included feelings of completeness and joy, inner life and the familiarity with transcendence (Duchon

and Plowman, 2005). According to Ashforth and Pratt (2010), workplace spirituality has three major facets: transcendence of self, holism and harmony, and growth. Pfeffer (2010) elaborated the four fundamental dimensions of workplace spirituality: interesting work and competence and mastery (allows employees to learn and develop); meaningful work (gives employees feeling of purpose); positive social relations with coworkers; and the ability to live an integrated life (allows synchronization of work roles and work demands).

Pandey et al. (2016) identified and measured four constructs of workplace spiritual climate: Swadharma, Lokasangraha, authenticity and sense of community. The authors clarified that there are two dimensions of Swadharma i.e. meaningful work and meditative work. Meaningfulness of work refers to work done for life not only for livelihood (Ashmos and Duchon, 2000). Meaningful work satisfies higher level needs and aspirations of the employees. McCormick (1994) referred to meditative work as experience of being totally absorbed in work and thus losing sense of self. Employee becomes one with the work and no separation remains between employee and work. Meditative work is a deeper aspect of spirituality that involves affective, behavioral part of self (Pandey et al., 2016). Sense of community has been elaborated with interconnectedness and interdependence among employees (Jurkiewicz & Giacalone, 2004). Morgan (1993) added another dimension (being comfortable with the world) in the concept of sense of community. Gardner et al. (2005) reported that authenticity involves genuineness and openness at workplace. Authenticity is operationally referred to synchronization of employees' actions and behaviors with their core, internalized cultural values and beliefs. The concept of Lokasangraha has been presented and clarified by Lord Krishna in Bhagawad Gita. It refers to oneness of entire universe. The idea of Lokasangraha involves welfare of all the people of the universe (Chakraborty, 2006) and well-being of humanity at large (Sebastian, 2003). Pandey et al. (2009) added concern for social and natural environment in Lokasangraha. In modern management literature, Lokasangraha is measured in terms of transcendence. The term transcendence means 'connection to something greater than oneself' (Ashforth and Pratt, 2003; Sheep, 2004). Charlene (1996) deciphers the four constructs of spirituality: Community, transcendent experience, intrinsic values and meaning and purpose in life.

Employee Engagement

Modern day practitioners and scholars have highlighted decrease in engagement level of employees at workplace (Bates 2004; Richman 2006). Scholars have coined a new term for such situation as 'engagement gap' (Kowalski 2003; Bates 2004; Johnson 2004). Workplace spirituality has evolved as one of the effective solutions to deal with dearth of employee engagement. Many firms are engrossed in creating spiritual workplaces that connect the hearts and minds of their workers (Pfeffer 2010). Employee engagement has been associated to the human spirit at work (May et al., 2004). Employee engagement and workplace spirituality are related to feeling of wholeness and completeness. Institutionalizing spirituality at workplace helps employee to experience completeness at workplace Kumar and Neck (2002). All literary definitions of spirituality indicate a sense of wholeness (Mlliman et al. 2003). Employee engagement includes the concurrent venturing of all aspects of oneself i.e. cognitive, physical and emotional in the performance (Kahn 1990). Thus spiritual workplace may induce full involvement of the employees. Kumar and Neck (2002) asserted that spirituality is an important dimension of human personality. And spirituality at workplace ensures that employees bring their complete self to work. Spirituality at workplace provides employee an opportunity to express various facets of self and not merely physical and intellectual facets of self (Ashmos and Duchon, 2000). Thus spirituality by its inherent nature tends to engage employees. Jurkiewicz and Giacalone (2004) elaborated that spiritual workplace provides a chance for integration of personal and professional self at workplace, engaging entire self in the work process. Workplace spirituality also helps in augmentation of interconnectedness between employees and it again have positive impact on employee involvement (Kumar and Neck 2002; Milliman et al. 2003). Indian spiritual values too inspire devotees to have full devotion and commitment for their job and organization. No organization can rise without devotion of its employees. Devotion for organization brings mutual faith and desire to take higher responsibility. It augments desire to share knowledge, expertise and wisdom with others (His Holiness Sri Sri Ravi Shankar, 2008). One of the revered Indian epic states that *'Bhutesu bhutesu vicitiya dhirah'* (Kena Upanisad) It means that one must look beyond individual differences to experience undivided and one supreme consciousness. The teaching bears great importance for modern organization

wherein employees to expected to ignore their personal differences and work towards organizational goal. Bhagwad Gita (shloka 3:9) suggested that one must work leaving behind their personal interests towards greater goal of the society. These theoretical inferences establish the linkage between spiritual workplace and employee engagement, but the association requires statistical confirmation especially in Indian settings. The present study tends to plug the gap in research.

Work Motivation

Tongo (2016) concluded that researchers of recent times have started to formulate contemporary theories that address the spiritual needs of employees at workplace. Notion that employees are motivated by their egocentric needs (eg. Social, self-esteem, power needs) has significant effect on motivational strategies of modern managers (Tongo, 2016). Recent incidence of corporate fraud, misappropriation and corruption indicates that actions of modern executives are influenced by individualistic and egocentric needs. In this pursuit of self- aggrandizement, well-being of other stakeholders (like customers, society) takes back seat. Organizational strategic choices are also influenced by greed of top executives of the firm Hambrick (2007). Such situations could be handled by practicing spirituality at work place. Spiritual values propel employees to act beyond the self while responding to the needs of others in different organizations and societies (Lindenberg and Foss, 2011). Clemmons and Fields (2011) found that soldiers' motivation to lead was positively influenced by their personal spirituality. As far as Indian epics are concerned, Bhagwad Gita is a master piece that combines spirituality with work motivation. Lord Krishna motivated Arjuna through spiritual sermons and knowledge to fight one of the most important wars of Indian history. One must work with hundred percentage commitment without fear of win-loss, profit-loss and happiness-sorrow (Bhagwad Gita, 2:38). Another shloka 2:47 also provides spiritual logic for work excellence stating that work is in the domain of a person but result is reflected back by nature or God. So, one must work fearlessly without any apprehensions of results. His holiness Sri Sri Ravi Shankar (2008) elaborated three pillars of work excellence. Firstly, Seva i.e. consider your job as a service to mankind and to God. This brings dedication and takes away feeling of meaninglessness from work life. Second is Satsang which means accompanying motivated, positive and knowledgeable persons. Satsang keeps one updated with recent happenings of the field and also motivates the persons to perform well. Lastly, Sadhana means practicing. Regular and periodic practices enhance focus and enrich one with relaxed mind. Focus sharpens the mind and relaxation expands the mind. Focused and relaxed mind improves performance and leads to improved work efficiency. All these spiritual inferences hint toward possible association between spirituality and work motivation. The paper tries to quantify this theoretical relationship between spirituality and motivation level of the employees.

Managerial Effectiveness

Managerial effectiveness is a crucial dimension that has been widely recognized by both practitioners and researchers in the field of organizational performance (Sharma et al., 2013). Managers are vital factors in ensuring organizational success by developing, formulating and implementing organizational strategies (Al-Madhoun and Analoui, 2004). Bao (2009) asserted that firms' target could not be achieved just by employing managers rather it requires effective managers. The effectiveness of managers has been a major concern for organizations (Shukla and Mishra, 2010). The classical view of managerial effectiveness emphasizes only on ability of managers to set and achieve goals (Bartol and Martin, 1991). After classists, situational paradigm of effectiveness emphasizes on situational variables like nature of task, position of managers (Bamel et al., 2011). Lately, organizational paradigm of managerial effectiveness put emphasis on ability of managers to create a vision for the organization (Srivastava and Sinha, 2007). Finally, individual paradigm focuses on one's capability to develop managerial skills and capabilities (Page et al., 2003). Practitioners and academicians have highlighted various factors that augment effectiveness of managers. Few factors responsible for effectiveness are manager's personality (Kumar et al., 2008; Rastogi and Dave, 2004), organizational culture (Pathak et al., 2009; Vallabh, 2010) and HR practices institutionalized in the organization (Ravichandran, 2011). Indian epics are epitome of virtues required for effective working of modern day managers. At the very starting of Mahabharta, Arjuna requested lord Krishna to take chariot in the middle of battle ground having equal distance from both armies. This reflects a perfect strategy of SWOT analysis prior to any major decision making process. Shloka 2:50 of Bhagwad Gita states *'Yogah Karmasu Kausalam'*. The sholka defines Yoga as skill in action. It emphasizes on

completion of task with the application of astute skills and knowledge. Same shloka also added that freedom from fever, feverishness and foolishness is the key of effectiveness. Another shloka 2:48 also states that *'Siddhy-asiddhyoh samo bhutva, samatvam yoga ucyate'*. The shloka advocates equanimity and calmness in every situation. It states that equanimity helps a person analyze a situation appropriately and thus leads to apt decision even in most depressing and challenging conditions. Another shloka 4:40 advised that the spirit of enquiry and quest is important for overall personality development of a person. Recent researches have started to explore the importance of workplace spirituality for managerial effectiveness. Muniapan and Satpathy (2010) exemplified Indian epic Valmiki Ramayana to depict importance of spiritual workplace. However, the study lacked empirical evidence. Later on, Sharma et al. (2013) provided statistical proof of positive association between workplace spirituality and managerial effectiveness. The present paper tends to investigate the statistical significance of relationship between spirituality and managerial effectiveness.

Objectives and Research Framework

The objective of the present research is to explore whether workplace spirituality could provide remedy for HR challenges of Indian insurance industry. Firstly, the paper tends to explore the status of workplace spirituality, employee engagement, work motivation and managerial effectiveness in Indian insurance companies. Secondly, the study explores the relationship between workplace spirituality and three employee level outcomes i.e. employee engagement, work motivation and managerial effectiveness.

The research setting for this empirical analysis is offices of insurance companies situated in every part of country. Data has been collected from all five geographical zones of India i.e. northern, southern, eastern, western and central zone. Subsequently, random sampling has been used to reduce chances of sampling biasness. While administering questionnaire, it has been ensured that data come from all categories like men, women, highly experienced to less experienced ones, aged personnel to fresh recruits, etc. Present study is based on a sample of 1098 employees working in various insurance companies. Sample comprises of 612 employees working in General Insurance Company, Life Insurance Corporation, Oriental Insurance Company Limited, National Insurance Company Limited, United Insurance Company Limited, New Indian Insurance Company and Agriculture Insurance Company. Rest 486 employees belong to private insurance companies like Reliance, ICICI Lombard, IFFCO tokio, Star health, Royal sundram, Max life, SBI Life etc. Female respondent comprised of only 20% of the sample, which means 218 of the total respondents were female and male employee contributed 80% that is 880 of the total respondents. The study revealed that out of the total sample surveyed, around 23% of them were below the age of 25 years. 59% of respondents were found within the age category of 26-35 years. 13% were within the age range of 36-45 years. 2% were within the age group of 46-55 years and the remainder 3% were found above the age of 55 years. The majority of the surveys participants (47%) have been employed for less than 5 years. 33% of employees were within the category of 5-10 years of work experience and 20% falls within the category of more than 10 years of work experience.

Primary data is collected through a structured questionnaire. Part A of the questionnaire captured the respondents' demography such as age, gender, work experience and educational qualification. Part B measured workplace spirituality with the help of scale developed by Pandey et al. (2009). Scale is based on four constructs of spirituality: Swadharama (meaningful work and meditative work), Authenticity, Lokasangraha and Sense of community (collaborative decision making). The scale has been modified by adding one additional construct i.e. Karma Capital. Bhagawad Gita, Astravakra Gita and Kena Upanisdha etc. highlighted that Indian spiritual concept is incomplete without inclusion of Karma theory. Karma theory states that one should put one's hundred percentages without expecting any fruits for the action (Gita, 2.47). One should be free from any impression of pleasure-sorrow, profit-loss, win- loss (Gita, 2.38). Further theory elaborates that good actions are reciprocated by nature in form of fruitful results (Brihadaranyaka Upanishad – 4.4.5). While interacting with saints, spiritual commentators, management expert in the field of management, it is revealed that Karma theory form basis of Indian spirituality. Thus, present paper investigates spirituality on seven point scale with the help of five constructs: Swadharama (5 statements), Authenticity (2 statements), Lokasangraha (3 statements), Sense of community (1 statement) and Karma capital (4 statements).

Part C investigated managerial effectiveness with the help of scale developed by Gupta (1996). The scale comprises of 45 items rated on a five-point rating scale, with 1

indicating disagreement and 5 indicating agreement with the statement. Part D explored employee engagement with the help of scale used by Garg and Sharma (2015). Employee engagement level is measured with the help of 72 statements. The main constructs of employee engagement were work environment (14 statements), leadership and direction (11 statements), relationship with immediate seniors and co-workers (14 statements), compensation program (4statements), job security and career development (7 statements), policies and work procedures of the company (6 statements), work-life balance (6 statements), and workplace well-being (10 statements). And finally part E of questionnaire comprises of 10 statements to measure employees' motivational level developed by Shouksmith (1989).

Reliability and validity of the measure has also been explored. Scale used for independent variables (Motivation, Engagement, and Managerial Effectiveness) has been sourced from previous literature and these scales have already been validated by their proponents. Four constructs of scale used for dependent variable (workplace spirituality) has been imported from Pandey et al. (2009). As far as new construct of Karma Capital is concerned, the construct posses good face validity. Statements has been derived after exploring teachings of Bhagwad Gita, Astravakra Gita and that of various spiritual leaders like Sri Sri Ravi Shankar, Rajneesh Osho etc. Further, reliability of the scale has been explored using Cronbach's alpha which is explained in table-2.

Descriptive statistics of four variables of study- spirituality, motivation, engagement and managerial effectiveness- is discussed. Correlation matrix provides an insight into association of these variables. Correlation hints towards probable association between two variables and regression helps in determining dependent variable with the help of independent variable. Regression analysis presumes that each cause is sufficient to increase the outcome but none is necessary. In regression, causality is additive. The relationship can be expressed as the additive model: Y = a + b1X1 + b2X2 + b3X3 . . . If one cause becomes zero, the resultant outcome will be reduced. This reduction in output could be compensated by increasing the values of other determinants. Thus regression analysis fails to predict necessity of an independent variable. The present paper proposes Necessary Condition Analysis (NCA) as a tool for identifying necessary conditions in data sets. NCA is used to explore whether workplace spirituality is necessary conditions for employee engagement, work motivation and managerial effectiveness. NCA is used in complementary with correlation and regression analysis. Presence of necessary condition does not ensure outcome, but without necessary condition outcome does not exist (Dul, 2016). Necessary cause is referred as a constraint, a barrier, an obstacle, a bottleneck that should be managed to allow a preferred result to exist. Every necessary condition is essential, as there is no additive causality that can compensate for the absence of the necessary condition (Dul, 2016; Mathieu and Taylor, 2006; Shadish, Cook, and Campbell, 2002). Without the necessary condition, there is definite failure, which cannot be compensated by other determinants of the outcome (Dul, 2016). This logic and its methodology are fundamentally different from the regression analysis. In case of Necessary Condition Analysis, absence of the necessary cause straight away results in outcome failure. Necessary causality is a multiplicative phenomenon: Y= X1. X2. X3….. (Goertz, 2003). Dul (2016) suggested that both NCA and regression should are complementary to each other. Both methods must be used together for better understanding and clarity.

Results

Exploration of three specific HR challenges of Indian Insurance Industry

Table-1: Descriptive Statistics of HR Challenges in Insurance Companies

HR Challenges	N	Mean	SD	t-value
Employee Engagement	1098	2.07	0.77	2.13*
Work Motivation	1098	2.12	0.82	2.21*
Managerial Effectiveness	1098	2.20	0.51	2.40*

*Source: Primary Data, * Sig at .05*

Table-1 gives elaborative description of employee engagement, work motivation and managerial effectiveness of employees working in Indian insurance companies. Mean value of employee engagement is very low (mean= 2.07) and t-value shows that this mean value of employee engagement is significantly lower than mid value (mid value= 2.5) of five-point scale used to measure employee engagement. It indicates that the value of employee engagement falls in lower half of five-point scale. Low statistical mean concludes lower level of engagement of employees of insurance companies. Further, mean value of work

motivation and managerial effectiveness are on lower side with value of 2.12 and 2.20 respectively. Again significant t-value confirms that the employee's motivation level and effectiveness of managers is a concern for insurance industry. The data substantiates the fact that the engagement, motivation and managerial effectiveness are serious HR challenges for Indian insurance companies.

Table-2: Variations in HR variables based on Ownership of Companies

HR Variables	Public Sector	Private Sector	t-value	Significance
Employee Engagement	2.11	1.87	2.23	0.32*
Work Motivation	1.69	2.36	2.78	0.31*
Managerial Effectiveness	2.17	2.23	7.84	5.93

*Source: Primary Data, * Sig. at .05*

Table-2 illustrates the variations in employee engagement, work motivation and managerial effectiveness among employees working in public and private sector insurance companies. Mean values and t-values indicate that employees of public sector insurance companies (mean=2.11) are significantly more engaged than employees of private sector insurance companies (mean=1.87). The probable reasons of relatively higher level of engagement among public sector employees are job security, less stringent marketing targets, higher level of wages and perks etc. On contrary to employee engagement, employees of private insurance companies are found to be statistically more motivated than employees of public sector employees. It means that work motivation is more grave challenge for management of public sector companies. As far as managerial effectiveness is concerned, insignificant t-value states that there is no difference in effectiveness of managers of companies of both sector.

Table-3: Variations in HR variables based on Nature of Business of Insurance Companies

HR variables	General Insurance	Life Insurance	t-value	Significance
Employee Engagement	2.03	2.10	9.03	8.11
Work Motivation	2.17	2.09	4.13	6.29
Managerial Effectiveness	2.01	2.31	6.72	5.73

*Source: Primary,*Sig at .05*

Table-3 elaborates the variations in employee engagement, work motivation and managerial effectiveness among employees working in general insurance and life insurance companies. Although mean value shows some difference in HR variables but t-value is insignificant for all three variables. It means that there exists no statistical significant variation in values of HR variables among general and life insurance employees. HR team of both general and life insurance needs equally potent tools to deal with problems of lower level of employee engagement, work motivation and managerial effectiveness.

Table-4: Employee Engagement and Individual based Variations

Variable	Category	Mean	t-value	Significance
Gender	Male	1.92	2.74	**0.01***
	Female	2.16		
Education	Under Graduate	2.25	2.25	**0.27***
	Graduate	1.98		
	Post Graduate	1.84		
Age	Below 25 years	1.63	7.79	2.83
	26- 35 years	1.79		
	36 - 45 years	1.72		
	46 - 55 years	2.01		
	Above 55 years	2.16		
Experience	Less than 5 years	1.83	8.02	3.14
	5- 10 years	2.03		
	More than 10 years	2.22		
Designation	Class 1 (Officers)	2.14	**1.52**	**0.00***
	Class 2 (Development Officers)	1.83		
	Class 3 (Clerical)	2.06		

*Source: Primary Data, *Sig at .05*

Table-4 provides good insights into demographic variable based variation in engagement level of employees. It is reported that female employees with mean value of 2.16 are more engaged at workplace than their male counterparts (mean=1.92). Significant t-value specifies that the difference in engagement level among genders is statistical significant. It specifies that management is required to adapt different strategies for male and female employees to augment their engagement level. It is also found that engagement of employees decreases with higher educational credentials. Post graduate employees (mean= 1.84) are reported to be least engaged with their firm. It highlights a significant challenge for top level management to keep highly qualified employees engaged. The problem could be resolved by assigning higher level of job responsibility and delegation of authority to such employees. Designation of employees is also established to have significant effect on engagement level of insurance employees. Marketing personnel (development officer) comes out to be least engaged with their respective insurance companies. The finding calls for marketing personnel specific HR initiatives to enhance their engagement level. Further, age and experience are found be insignificant differentiator of employee engagement and hence are not analyzed in detail.

Table-5: Work Motivation and Individual based Variations

Variable	Category	Mean	t-value	Significance
Gender	Male	1.85	1.72	**0.07***
	Female	2.30		
Education	Under Graduate	2.47	2.36	**0.35***
	Graduate	2.02		
	Post Graduate	1.69		
Age	Below 25 years	2.38	2.98	**0.41***
	26- 35 years	2.20		
	36 - 45 years	2.12		
	46 - 55 years	2.05		
	Above 55 years	1.93		
Experience	Less than 5 years	2.18	9.62	1.19
	5- 10 years	2.54		
	More than 10 years	1.86		
Designation	Class 1 (Officers)	2.12	0.72	**0.01***
	Class 2 (Development Officers)	2.31		
	Class 3 (Clerical)	1.82		

*Source: Primary Data, * Sig. at .05*

Table-5 explores demographic variable based variation in motivation level of workforce employed in Indian insurance companies. It is concluded that female workers (mean=2.30) are significantly more motivated than male workers (mean=1.85). It is noteworthy to remind that women were reported more engaged than men in previous table. It signifies that female employees present relatively mild HR challenge than their male counterparts. It is interesting to note that motivation level tends to decrease with age of the employees. T-value is observed to be significant for age; it established age as statistical significant moderator of workplace motivation. Based on findings, HR officials of insurance companies are suggested to institutionalize different tenants of motivation to keep aging employees motivated at workplace. Various intervening theories like job characteristics theory, social exchange theory, Ability- Motivation- Opportunity theory etc. could provide guiding light to HR practitioners. In contrary to findings of engagement table, it is reported that marketing personals are relatively more motivated than administrative personals. Probable reason for such interesting findings may be system of monetary and non- monetary benefits in terms of incentive, premium commission, car or other perks.

Table-6: Managerial Effectiveness and Individual based Variations

Variable	Category	Mean	t-value	Significance
Gender	Male	2.09	5.43	11.43
	Female	2.31		
Education	Under Graduate	1.92	2.34	**0.05***
	Graduate	2.16		
	Post Graduate	2.41		
Age	Below 25 years	1.88	1.68	**0.03***
	26- 35 years	1.94		
	36 - 45 years	2.24		
	46 - 55 years	2.39		
	Above 55 years	2.20		
Experience	Less than 5 years	2.01	2.00	**0.04***
	5- 10 years	2.26		
	More than 10 years	2.47		
Designation	Class 1 (Officers)	2.20	6.92	13.13
	Class 2 (Development Officers)	2.17		
	Class 3 (Clerical)	2.31		

*Source: Primary Data, *Sig. at .05*

Table-6 tends to identify significant demographic variable that have statistical considerable impact on managerial effectiveness. T-value reveals that gender and designation are insignificant variable for managerial effectiveness. Further, it was observed that the managerial effectiveness increases with age and experience of the employees. These effective seasoned employees could be used as mentor or guide for young employees. The suggested practice would help an organization to intermingle managerial success of elder employees with enthusiasm and creativity of young generation. This could lead to better career planning, career development and succession planning in insurance companies. It is also revealed that managerial effectiveness increases with educational qualifications of the employees of insurance companies. It is appealing to remind that employee engagement and work motivation were reported to decline with academic qualifications. It represents a highly contrasting situation that a highly qualified employee is effective but he becomes less engaged and less motivated. The finding highlights poor implementation of fundamental HR practices and signifies that the insurance companies are suffering from under utilization, poor Human Resource Planning, ineffective employee placement, inadequate Human Resource Auditing and nearly non- existent Human Resource Information System.

> HR officials of insurance companies are suggested to institutionalize different tenants of motivation to keep aging employees motivated at workplace. Various intervening theories like job characteristics theory, social exchange theory, Ability- Motivation-Opportunity theory etc. could provide guiding light to HR practitioners.

Exploration of Workplace Spirituality in Indian Insurance Industry

Table-7: Workplace Spirituality in Insurance Companies

Constructs of Workplace Spirituality	N	Mean	SD	t-value
Swa-dharama	1098	2.97	0.711	1.32*
Karma Capital	1098	3.20	0.693	2.20*
Sense of community	1098	3.29	0.834	5.92
Lok-asangraha	1098	2.42	0.496	1.64*
Authenticity	1098	2.18	0.595	2.25*
Overall Workplace Spirituality	1098	2.81	0.432	2.62*

*Source: Primary Data, *Sig. at .05*

Table-7 investigates the status of workplace spirituality among employees working in Indian insurance companies. Overall workplace spirituality has a mean value of 2.81 and it is noteworthy of remind that a seven point scale has been just to measure spirituality at workplace. Significant t-value indicates that the mean value of 2.81 is statistically significantly lower than mid value of seven point scale. The finding hints towards need to institutionalize various spiritual practices like Yoga, meditation, pranayam, cognitive thought restructuring etc. to improve spiritual aspect of work. Among five constructs of workplace spirituality, sense of community has highest mean value of 3.29. Moreover t-value of the construct is also insignificant which shows healthy sign of presence of sense of community among employees. Authenticity (mean=2.18) is observed as a matter of concern for insurance companies. It reflects lack of transparency and accountability and opaque style of management in these Indian insurance companies.

Table-8: Variations in Workplace Spirituality based on Ownership of Companies

Constructs of Workplace Spirituality	Public Sector	Private Sector	t-value	Sig.
Swadharama	3.32	2.72	1.83	0.12*
Karma Capital	3.09	3.29	8.78	2.78
Sense of community	3.32	3.17	0.87	0.13*
Lokasan-graha	2.42	2.42	5.63	2.03
Authenticity	1.90	2.29	1.22	0.48*
Overall Workplace Spirituality	2.82	2.74	9.42	2.43

*Source: Primary Data, *Sig. at .05*

Table-8 defines variation in workplace spirituality experienced by employees of public and private insurance companies. Data reveals no significant variation in the values of overall workplace spirituality. Mean value of Swadharama is significantly higher for public sector employees. It reflects that public sector employees consider their work as service to humanity. Further, sense of community is also reported to vary significantly among employees of both sectors. It means that employees of public companies feels more interconnected and related to each other than employees of private companies. There is greater sense of oneness and team spirit among government employees.

It is fascinating to observe that authenticity has significantly higher value for private employees. The findings are in accordance with common belief that working and processes of private companies are more transparent and open. Other two constructs of workplace spirituality i.e. Karma Capital and Lokasangraha are established as insignificant variables.

Table-9: Variations in Workplace Spirituality based on Nature of Business of Companies

Constructs of Workplace Spirituality	General Insurance	Life Insurance	t-value	Sig.
Swadharama	3.12	2.97	5.43	4.83
Karma Capital	3.11	3.27	5.07	3.82
Sense of community	3.51	2.92	7.64	0.56
Lokasan-graha	2.38	2.50	4.82	3.93
Authenticity	1.78	2.39	7.83	6.93
Overall Workplace Spirituality	2.78	2.81	3.94	3.92

*Source: Primary Data,*Sig. at .05*

Table-9 illustrates variations in workplace spirituality among employees of general and life insurance companies. It is reported that neither overall spirituality nor any of its construct vary significantly among employees of general and life insurance.

Table-10: Swadharama and Individual based Variations

Variable	Category	Mean	t-value	Significance
Gender	Male	2.63	1.94	0.35*
	Female	3.35		
Education	Under Graduate	2.96	7.84	4.95
	Graduate	2.99		
	Post Graduate	2.81		
Age	Below 25 years	2.64	0.97	0.00*
	26- 35 years	2.77		
	36 - 45 years	2.79		
	46 - 55 years	2.96		
	Above 55 years	3.17		
Experience	Less than 5 years	2.58	2.74	0.46*
	5- 10 years	2.80		
	More than 10 years	3.04		
Designation	Class 1 (Officers)	2.91	6.53	5.93
	Class 2 (Development Officers)	2.84		
	Class 3 (Clerical)	2.99		

*Source: Primary Data,*Sig. at .05*

Table-10 explores demographic variable based variation in Swadharama of workforce employed in Indian insurance companies. Out of five variables, three variables (gender, age and experience) are reported to cause deviation in swadharama among different categories. Female employees (mean=3.35) have significant higher value than their male counterparts (mean=2.63). It is also observed that feeling of meaningful and meditative work increases with age and experience of the employees. It reflects that the sense of meaningfulness and interest in job increases with age and stay of employees with organization.

Table-11: Karma Capital and Individual based Variations

Variable	Category	Mean	t-value	Significance
Gender	Male	3.03	1.93	0.38*
	Female	3.42		
Education	Under Graduate	2.86	9.74	2.83
	Graduate	3.43		
	Post Graduate	2.66		
Age	Below 25 years	3.42	1.72	0.12*
	26- 35 years	3.29		
	36 - 45 years	3.12		
	46 - 55 years	2.88		
	Above 55 years	2.67		
Experience	Less than 5 years	3.31	2.83	0.45*
	5- 10 years	2.80		
	More than 10 years	2.47		
Designation	Class 1 (Officers)	3.20	8.65	2.83
	Class 2 (Development Officers)	3.20		
	Class 3 (Clerical)	3.19		

*Source: Primary Data,*Sig. at .05*

The construct Karma capital has special relevance in Indian settings. No other culture so vast and so diverse meaning of Karma. Table-11 tends to identify the variables that cause variations in Karma capital. Female employee of insurance companies scores significantly higher than male employees. The basic philosophy of Indian karma theory is 'work without fear of results, failure and success'. The data reveals that employees start believing and practicing in karma theory with age and experience. Other two variables- education qualification and designation- are reported insignificant.

Mean value of Swadharama is significantly higher for public sector employees. It reflects that public sector employees consider their work as service to humanity. Further, sense of community is also reported to vary significantly among employees of both sectors. It means that employees of public companies feels more interconnected and related to each other than employees of private companies. There is greater sense of oneness and team spirit among government employees.

Table-12: Authenticity and Individual based Variations

Variable	Category	Mean	t-value	Sig.
Gender	Male	3.28	3.54	2.93
	Female	3.39		
Education	Under Graduate	2.83	1.84	0.03*
	Graduate	3.12		
	Post Graduate	3.34		
Age	Below 25 years	3.42	1.93	0.07*
	26- 35 years	3.64		
	36 - 45 years	3.15		
	46 - 55 years	3.14		
	Above 55 years	3.00		
Experience	Less than 5 years	3.68	2.18	0.23*
	5- 10 years	3.37		
	More than 10 years	3.19		
Designation	Class 1 (Officers)	3.30	7.82	6.93
	Class 2 (Development Officers)	3.40		
	Class 3 (Clerical)	3.37		

*Source: Primary Data, *Sig. at .05*

Table-12 identifies significance of deviance in authenticity among five demographical variables. It is observed that perception of fair, transparent and open organizational culture increases with age and experience. The findings are quite understandable from the fact that as employee climbs the ladder of the career with age and experience, the employee develops greater understanding and awareness of reason and rationale behind any decision or initiative. This enhanced understanding augments acceptability of decision taken by top management and hence feeling of fairness and transparency increases. It has also been reported that mean score of authenticity increases with academic credentials of the employees.

Table-13: Sense of Community and Individual based Variations

Variable	Category	Mean	t-value	Significance
Gender	Male	2.12	2.18	0.19*
	Female	2.73		
Education	Under Graduate	2.34	10.11	4.03
	Graduate	2.46		
	Post Graduate	2.39		
Age	Below 25 years	2.19	1.10	0.13*
	26- 35 years	2.34		
	36 - 45 years	2.26		
	46 - 55 years	2.44		
	Above 55 years	2.56		
Experience	Less than 5 years	2.32	2.08	0.15*
	5- 10 years	2.40		
	More than 10 years	2.57		
Designation	Class 1 (Officers)	2.22	4.93	3.94
	Class 2 (Development Officers)	2.46		
	Class 3 (Clerical)	2.30		

Source: Primary Data, Sig. at .05*

Table-13 studies variations in fourth construct of workplace spirituality (sense of community) among different demographic variables. Female employees (mean=2.73) of insurance companies score significantly higher than male employees (mean=2.12). It compliments with common belief of HR practitioners that the women are more sociable. It has also been stated that the interconnectedness and interdependence of employees increases with age and experience of the employees.

Various constructs of workplace spirituality are observed to have positive relation with all three HR variables of the present study. In simple words, institutionalization of even one construct of workplace spirituality could help Indian insurance companies to cope up with problems of low employee engagement and low work motivation. Effectiveness of employees also gets a boost with implementation of spirituality at workplace.

Table-14: Lokasangraha and Individual based Variations

Variable	Category	Mean	t-value	Sig.
Gender	Male	2.32	3.92	2.83
	Female	2.14		
Education	Under Graduate	2.33	6.73	5.94
	Graduate	1.93		
	Post Graduate	2.19		
Age	Below 25 years	2.39	4.68	3.71
	26- 35 years	2.10		
	36 - 45 years	2.13		
	46 - 55 years	2.43		
	Above 55 years	2.10		
Experience	Less than 5 years	2.18	2.84	1.74
	5- 10 years	2.22		
	More than 10 years	2.15		
Designation	Class 1 (Officers)	2.13	5.84	4.03
	Class 2 (Development Officers)	2.12		
	Class 3 (Clerical)	2.32		

*Source: Primary Data, *Sig. at .05*

Table-14 investigates the deviance in Lokasangraha among five demographical variables. It is appealing to notice that none of the demographic variable is potent enough to cause any variation in Lokasangraha.

Exploration of Relationship Between Workplace Spirituality and HR Variables

Table-15 represents correlation matrix and cronbach's alpha values. Any values greater than 0.70 of crobach's alpha is considered as reliable. Correlation matrix shows that although independent variables are correlated but relationship between them is not significant. Thus all these variables could be taken as unique and different dimension

Table-15: Correlation Matrix and Cronbach's Alpha Values

Variable	SD	A	SC	LS	KC	EE	WM	ME
SD	(0.72)							
A	0.23	(0.82)						
SC	0.27	0.22	(0.78)					
LS	0.35	0.31	0.27	(0.80)				
KC	0.18	0.28	0.31	0.25	(0.90)			
EE	0.58*	0.76*	0.65*	0.57*	0.74*	(0.88)		
WM	0.59*	0.70*	0.79*	0.60*	0.67*	0.73*	(0.73)	
ME	0.61*	0.54*	0.66*	0.55*	0.49*	0.63*	0.45	(0.70)

Source: Primary Data

*SD- Swadharama, A- Authenticity, SC- Sense of Community, LS- Lokasangraha, KC- karma Capital, EE- Employee Engagement, WM- Work Motivation, ME- Managerial Effectiveness Cronbach's alpha is in parentheses, *Sig at .05*

of workplace spirituality. It is also reported that the correlation between nearly all (except correlation between ME and WM) is significant. It signifies that increase in value of workplace spirituality will lead to corresponding increment in values of dependent variables (Employee engagement, work motivation and managerial effectiveness). Various constructs of workplace spirituality are observed to have positive relation with all three HR variables of the present study. In simple words, institutionalization of even one construct of workplace spirituality could help Indian insurance companies to cope up with problems of low employee engagement and low work motivation. Effectiveness of employees also gets a boost with implementation of spirituality at workplace.

An in-depth exploration of association between workplace spirituality and dependent variables could be done with the help of Necessary Condition Analysis. Researchers have recommended two main parts in NCA: (1) determining ceiling lines and the corresponding bottleneck tables and (2) calculating other parameters like accuracy of the ceiling line, effect size of the necessary condition, and necessity inefficiency. The starting point for the NCA is a scatter plot of data using a Cartesian coordinate system. Determinant is plotted along X axis while outcome is plotted along Y axis (Dul, 2016). If upper left corner of graph is reported empty then necessary condition may be said to exist. Then a ceiling line between the empty zone (zone without observations) and the full zone with observations is drawn. In ideal conditions, all observations lie below ceiling line. There are various methods of plotting ceiling lines. Dul (2016) preferred CE-FDH (ceiling

envelopment with free disposal hull) as the method is known for producing stable results with relatively large ceiling zones. Next step to observe effect size whose value lies from 0 to 1. Dul (2016) proposed segregation of effect size as: 0< d < 0.1 as a small effect. Value equal or greater than 0.1 to 0.3 is regarded as medium effect, values in range of 0.3 ≤ d < 0.5 is categorized as large effect and finally all values greater or equal than 0.5 is taken as very large effect. Dul (2016) marked 0.1 as threshold limit for Necessary Condition such that effect size greater than 0.1 indicates necessary variable. Accuracy represents number of observations that does not lay in the empty space, divided by the total number of observations, multiplied by 100%. If accuracy ≥95% and size effect is large enough, then necessary condition is confirmed (Dul, 2016).

Figure-1: NCA Plot- Workplace Spirituality and Employee Engagement Level

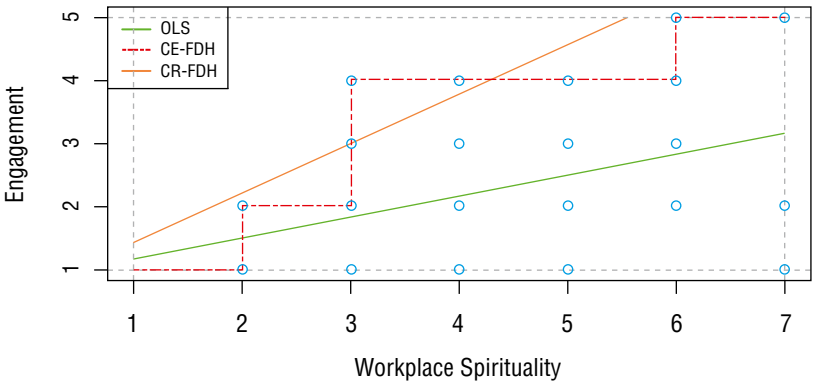

Figure-1 presents NCA plot for workplace spirituality and employee engagement level. There are two default ceiling lines: CE-FDH (Ceiling Envelopment – Free Disposal Hull) in red and the straight line CR-FDH (Ceiling Regression – Free Disposal Hull) in orange. The CE-FDH (step ceiling line) must be used when the data is discrete with limited number of levels. CR-FDH (straight ceiling line) should be used when data is discrete with a large number of levels. The present study is discrete and have relatively larger sample of 1098 respondents. It is observed that upper left zone of plot is empty which means that necessary condition may exist. In other words, workplace spirituality is necessary but sufficient condition for employee engagement. The finding has great relevance for Indian insurance industry. Top management is suggested to look for spirituality as a necessary pre-condition for higher level of employee engagement.

Table-16: Effect Size and Other Statistics (Workplace Spirituality and Engagement)

Statistics	CE-FDH	CR-FDH
Ceiling Zone	9.0	6.2
Effect Size	0.375	0.259
Accuracy	100%	99.5%
Condition Inefficiency	16.67	22.72
Outcome Inefficiency	25.00	32.83

Table-16 represents effect size, accuracy and necessity inefficiency for NCA applied to explore necessary condition of workplace spirituality for employee engagement. Effect size is 0.375 for CE-FDH, which means effect size is 'large' enough to confirm necessary condition. Accuracy (99.5%) is well above 95%, it also confirms that workplace spirituality is a necessary condition for employee engagement.

Figure-2: NCA Plot- Workplace Spirituality and Work Motivation

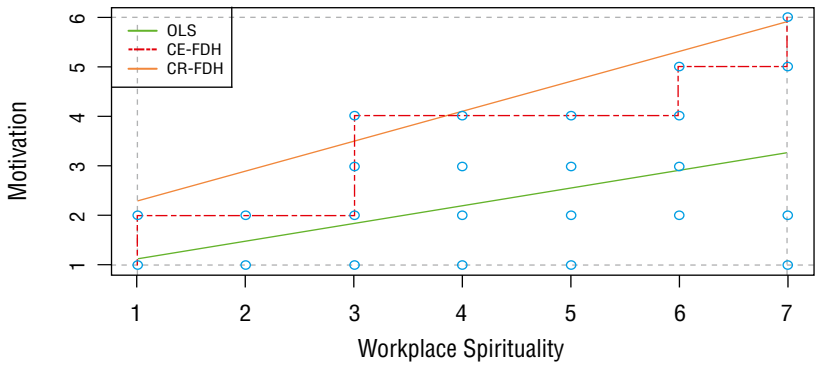

Figure-2 presents NCA plot for workplace spirituality and employee engagement level. In this case too, Ceiling Regression – Free Disposal Hull (CR-FDH) is considered for explanation purpose. It is again observed that upper left zone of plot is empty which means that necessary condition may exist. It confirms that, workplace spirituality is necessary but sufficient condition for work motivation. Highly motivated workforce is a real asset for any firm. The findings reveal that spirituality at workplace could ensure high motivation potential score among employees of Indian insurance companies. A number of companies such as Prentice Hall Publishing are establishing quite or meditation rooms for their employees. Similar practice of meditation halls at workplace or sponsoring meditation courses for

employees could help HR practitioners to deal with grim issue of motivation.

Table-17: Effect Size and Other Statistics (Workplace Spirituality and Motivation)

Statistics	CE-FDH	CR-FDH
Ceiling Zone	15.0	11.407
Effect Size	0.500	0.380
Accuracy	100%	99%
Condition Inefficiency	0.00	0.00
Outcome Inefficiency	20.00	25.71

Table-17 provides NCA related statistics to explore necessary condition of workplace spirituality for work motivation. Effect size is 0.380 for CE-FDH, which means effect size is 'large' enough to confirm necessary condition. Accuracy (99%) is well above 95%, it also confirms that workplace spirituality is a necessary condition for work motivation also.

Figure-3: NCA Plot- Workplace Spirituality and Managerial Effectiveness

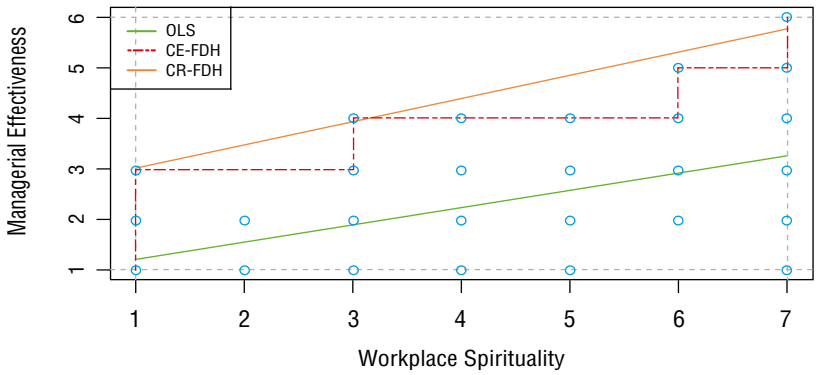

Figure-3 provides NCA plot for workplace spirituality and managerial effectiveness level. Again, Ceiling Regression – Free Disposal Hull (CR-FDH) is used here too, as data is discrete one. It is again reported that upper left zone of plot is empty which means that necessary condition may exist. It substantiates that the workplace spirituality is necessary but sufficient condition for managerial effectiveness. Effectiveness of employees is a function of creativity, innovation, concentration and persistence. Biomedical researchers have proved that mediation and prayer activates special neurons of the brain and activation of these neurons is directly related with higher level of innovation and creativity. Concentration is a nature outcome of yoga, pranayam and meditation. Cognitive thought restructuring (A vedic spiritual technique) resolves cognitive dissonance and confusion during decision making and help managers to arrive at optimal decision.

Table-18: Effect Size and Other Statistics (Workplace Spirituality and Managerial Effectiveness)

Statistics	CE-FDH	CR-FDH
Ceiling Zone	13.00	9.62
Effect Size	0.433	0.323
Accuracy	100%	98.5%
Condition Inefficiency	10.67	13.62
Outcome Inefficiency	26.12	40.00

Table-18 illustrates effect size and other related statistics to explore necessary condition of workplace spirituality for managerial effectiveness. Effect size is 0.323 for CE-FDH, which means effect size is 'large' enough to confirm necessary condition. Accuracy (98.5%) is well above 95%, it also confirms that workplace spirituality is a necessary condition for managerial effectives also.

Table-19: Multiple Regression Result (Workplace Spirituality and Employee Engagement)

Independent Variable	Unstandardized Coefficient β	Standardized Coefficient β	t-value	VIF
Constant	2.632			
Swadha-rama	0.814	0.846	3.75*	2.42
Karma Capital	0.764	0.793	4.41*	4.87
Sense of community	0.816	0.832	1.98*	4.63
Lokasan-graha	0.683	0.693	2.12*	1.70
Authenticity	0.692	0.712	2.43*	3.84

*(Source: Primary Data, *Sig at 0.05)*

Hair et al., (1998) recommended that VIF value should be less than 10 to avoid problem of multi co-linearity. Result suggests that there is no problem in multi co-linearity in the study. Result also suggest that all constructs of workplace spirituality are significant predictor of employee engagement (as standard coefficient $\beta > 0$, t-value is also significant for all independent variables). Following regression equation could be derived from table-19.

EE = 2.632 + 0.846 SD + 0.793 KC + 0.832 SC + 0.693 LS + 0.712 A

The above equation derives a causal relationship between employee engagement and various constructs of workplace spirituality. This is

amply clear from above regression equation that all construct of spirituality have positive impact on employee engagement. Largest impact has been observed by Swadharama (β = .846) followed by sense of community (β = .832). A manager could elicit desired level of employee engagement by varying level of workplace spirituality.

Table-20: Result of Standard Regression (Overall Workplace Spirituality)

Depen-dent Variable	Independent Variable	R	R^2	F-value	Sig.
Employee Engagement	Workplace Spirituality	0.81	0.64	74.67	0.044**

*(Source: Primary Data, *Sig at.05)*

Table-20 asserts that the overall workplace spirituality is a significant predictor of employee engagement at workplace. Based on results, 64% of variations in employee engagement are defined by workplace spirituality. These findings are complementary with that of Kumar and Neck (2002), Pratt and Ashforth (2003) and Ashmos and Duchon (2000). Although, findings are identical but present study and previous studies are based on different dimensions of workplace spirituality. It is also interesting to note that these studies are conducted in different settings. Results could also be understood from the work of Ashmos and Duchon (2000). They reported that feeling of serving a purpose beyond self-interest developing sense of meaningful at workplace and hence employee gets completely engrossed and soaked by work.

Table-21: Multiple Regression Result (Workplace Spirituality and Work Motivation)

Indepen-dent Variable	Unstandardized Coefficient β	Standardized Coefficient β	t-value	VIF
Constant	1.038			
Swadha-rama	0.742	0.763	6.75*	4.85
Karma Capital	0.797	0.898	5.12*	7.92
Sense of community	0.653	0.693	2.43*	8.76
Lokasan-graha	0.741	0.772	1.74*	3.84
Authenticity	0.824	0.842	2.22*	4.29

*(Source: Primary Data, *Sig at 0.05)*

Table-21 concludes that all dimensions of workplace spirituality are significant predictor of work motivation (as standard coefficient β > 0, t-value is also significant for all independent variables). VIF values suggest lack of problem of multi co-linearity. Following regression equation could be derived from above depicted table.

WM = 1.038 + 0.763 SD + 0.898 KC + 0.693 SC + 0.772 LS + 0.842 A

The above equation defines the causal association between work motivation and five constructs of workplace spirituality. Swadharam is observed to have least impact on work motivation and Karma Capital is reported to have highest impact on motivation level of the employees.

Table-22: Result of Standard Regression (Overall Workplace Spirituality)

Dependent Variable	Independent Variable	R	R^2	F-value	Sig.
Workplace Motivation	Workplace Spirituality	**0.71**	**0.49**	**47.73**	**0.047****

*(Source: Primary Data, *Sig at 0.05)*

Table-22 confirms significant association between overall workplace spirituality and motivation level of employees. Result suggests that 49% variation in motivation is governed by workplace spirituality. Thus, finding establishes spirituality as an effective indicator of work motivation. Results confirms the findings of Hall and Chandler (2005), Rosso et al. (2010), Dobrow (2013) etc, although in different cultural environment and with the help of different constructs of both dependent and independent variables. Findings could be seen from the eyes of Sarin's contributory theory of existence and Perry's process theory of public service motivation. Perry (2000) stated that spirituality induces motivation through eliciting a feeling of public service among employees of insurance companies. Sarin (2009) accentuates that spirituality induces a moral obligation to give back to society that an individual has once benefitted from. These theories associate spirituality with motivation stating that humans are solely motivated to sustain a symbiotic relationship initiated by the larger society.

Table-23: Multiple Regression Result (Workplace Spirituality & Managerial Effectiveness)

Independent Variable	Unstandardized Coefficient β	Standardized Coefficient β	t-value	VIF
Constant	0.833			
Swadharama	0.773	0.793	4.12***	8.83
Karma Capital	0.810	0.849	1.73*	9.62
Sense of community	0.651	0.683	1.68*	3.36
Lokasangraha	0.608	0.611	2.34**	7.29
Authenticity	0.712	0.820	2.02**	8.96

*(Source: Primary Data, *Sig at 0.05)*

Based on results shown by table-23, all five constructs of workplace spirituality are significantly associated with effectiveness of managers in their official capacity. VIF values are appropriate to avoid any deviation due to multi co-linearity of data. T-statistics reveals that all predictors are significant. Following regression equation has been derived.

ME = 0.833 + 0.793 SD + 0.849 KC + 0.683 SC + 0.611 LS + 0.820 A

The above equation establishes a causal relationship between managerial effectiveness and various constructs of spirituality t workplace. Maximum impact is shown by Karma capital followed by authenticity.

Table-24: Result of Standard Regression (Overall Workplace Spirituality)

Dependent Variable	Independent Variable	R	R^2	F-value	Sig.
Managerial Effectiveness	Workplace Spirituality	0.69	0.47	79.93	0.038**

*(Source: Primary Data, *Sig at 0.05 level)*

Table-24 provides statistical evidence of significant association between overall workplace spirituality and managerial effectiveness. As per results, 49% variations in managerial effectiveness are described by workplace spirituality. Thus, finding suggests that spirituality could become a handy tool for managers and managers could augment their effectiveness through workplace spirituality. Similar sort of findings were also reported by Sharma et al, (2013). The most probable cause for such kind of results may be that intense competitive and target bound business environment requires spirituality at workplace to develop an environment of positive energy and positive attitude towards self and others. This heightened level of positivity around a manager increases managers' effectiveness (Sengupta, 2010).

Discussion and Conclusion

Managerial effectiveness, employee engagement and work motivation are considered three vital components of workplace management. The study intends to enrich this issue by exploring the connection between workplace spirituality and these three outcome variables. The above mentioned results establish workplace spirituality as 'necessary' determinant of managerial effectiveness, employee engagement and work motivation. This indicates that statistically it is not possible to achieve effectiveness, engagement and motivation without institutionalizing spirituality at workplace. The present study is probably the first to apply Necessary Condition Analysis in a study of workplace spirituality. Further, all five constructs of workplace spirituality i.e. Swadharama, Sense of Community, Authenticity, Karma Capital and Lokasangraha, are significant predictor of all three criterion variables. Therefore, it is suggested that management must institutionalize spirituality in organizational vision, mission, policies and practices so that true potential of workplace spirituality could be visualized in every aspect of work-life. It will help employees to realize true meaning of their dharama, experience community feeling, appreciate results without feverishness and understand interconnectedness. These all are intended to increase productivity at workplace. Saks (2009) suggested that the workplace spirituality should not be seen as universal remedy for organizational problems of engagement and ineffectiveness nor should spirituality be used as a manipulative attempt to improve employee performance. Rather, organizations should develop a holistic spiritual organizational climate that helps employees to realize their true potential. And then this potential could be channelized the appropriate direction of organizational effectiveness.

The study also provides another ancient dimension of Indian spiritual values – Karma theory. Although the Karma philosophy has been part and parcel of all Indian scriptures but somehow, it misses empirical investigation of modern researchers. It is noteworthy to mention that Indian meaning of spirituality is incomplete without inclusion of Karma theory. Renowned spiritual Indian guru 'Sri Sri Ravishankar

ji' has equated Karma to spine of Indian spiritual philosophy. In this background, new construct seems to be an apt and supplementary inclusion.

In spite of its unique methodology and findings, the present paper has certain limitations too. Firstly, the sample selected for the study involves only companies situated in National Capital Region of India thus generalization of the findings may not be done until sample includes employees from around the country. Secondly, a larger sample size would have made the study more worthwhile. Lastly, present work used cross-sectional approach. No researcher can confidently claim causal relations based on cross sectional studies. Thus results of present studies could be confirmed through any longitudinal exploration. Future researchers may further explore workplace spirituality by conceptualizing and measuring workplace using both qualitative and quantitative approach. Researchers could explore integration of apparently different topics like spirituality and employee-level outcomes (attitude, organizational commitment, engagement etc.) which has the potential to enrich our knowledge and understanding of both. This re-synthesis, could lead to new and exciting research that can benefit individuals and organizations. Further, the methodology adapted in the study could be replicated in other cultures but with different dimensions of spirituality.

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Merit Winner

D. Subramaniam Award Essay Writing Competition

Insurance Ombudsman – External Dispute Resolution in Insurance Industry

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Abstract

The research paper tries to understand one of the important organs of insurance industry the ombudsman. The insurance industry, which is prone to various types of complaints, needs an external dispute resolution mechanism. This mechanism is in form of insurance ombudsman. The paper consists of 6 sections.

I – Introduction deals with the brief requirement of insurance ombudsman.

II – It consists of various subsections which describe the system of Indian insurance starting from legal framework of insurance ombudsman. It deals with the structure of ombudsman in India; the System of filing complaints

and how the ombudsman resolves such complaints through various methods like Award recommendation etc.

III – This section has two sub sections: Section one is on analysis of the performance and working of the scheme in India with respect to financial year 2015-16. It mainly analyses (a) disposal of complaints and time line, (b) nature wise complaints received, (c) Human resources assisting ombudsman and (d) Revenue and expenditure. This section ends with inferences based on observation of analysis. The other section studies the trends over a period of 4 years and makes inferences.

IV – This section deals with international principles and practices of financial ombudsman system and a comparison of Indian insurance ombudsman is made vis-a-vis these international standards. The section ends with inference that the Indian system is at par with the best of world system in terms of application of principles.

V) – Here a small study of the Financial Ombudsman Service of United Kingdom and Financial Ombudsman Institution of Taiwan is done. The purpose behind this is to identify global best practices and compare with Indian system to understand areas for improvement.

VI – The last section has suggestions for improving the Insurance ombudsman scheme. It includes revisiting RPG rules of 1998, online system of complaint filing, reworking of financing method of the scheme, penalties for non - implementation of orders, Reworking of system and process to reduce Turnaround Time.

Finally the paper concludes with the expectation that though the scheme is doing well there is much scope for improvement.

Introduction

Adam Smith the father of modern economics said "consumption is the sole end and purpose of all production; and the interest of the producer ought to be attended to, only so far as it may be necessary for promoting that of the consumer". Thus, consumer is the focal point of all production and consumption and his and only his interest forms the basis of all economic activity.

Insurance is basically a business of contract management, spiced up with actuarial science and information processing. The consumption of insurance services is devoid of any physical good and thus has its own basic characteristics. Many a time while entering an insurance contract there are inherent asymmetries of information due to various reasons like technical jargon, vested interest of intermediaries involved, low level of financial literacy, casual approach towards purchase of insurance and pressure to mop up new business without qualitative underwriting. This and many more reasons lead to denial of performance of contract by the insurers, citing breach of the doctrine of "uberrimae fidei" or utmost good faith most of the time.

Such incidences of denial are flash points in the relationship between a policyholder on one side and intermediaries and insurers on the other, which gives rise to grievance. There are well laid out regulations, like Policyholder Protection Regulations of IRDAI, to deal with grievances of the policyholder. However, a system of External Dispute Resolution (EDR) provides fairness and equity and is perceived to be trustworthy. The Insurance Ombudsman Scheme of the Governing Body of Insurance Council (GBIC) is the system for insurance industry in India.

Insurance Ombudsman in India

Objective and legal framework

The legal framework for establishment of the office of insurance ombudsman is the "Redressal of Public Grievances Rules, 1998" (RPG Rules 1998)[1].
The main objective of these rules is to resolve all complaints related to settlement of claim part of insurance companies in a cost effective, efficient and impartial manner. Thus, the office of insurance ombudsman acts as a third party mediator to resolve complaints of policyholders referred to them in a manner prescribed by the rules.

The following mission statements of IRDAI clearly define protection of the interest of policyholder:

To protect the interest of and secure ***fair treatment to policyholders*** and

to ensure speedy settlement of genuine claims, to prevent insurance frauds and other malpractices and put in place ***effective grievance redressal machinery;***

The insurance ombudsman plays an important role as a neutral entity, in fulfilling the objectives of the above mission statements of IRDAI:

Structure

As per the RPG rules, the Governing Body of Insurance Council of (GBIC) has been established to facilitate the Institution of Insurance Ombudsman in India. All the insurance companies are represented in the GBIC. The representative from the insurance company can be the Chairman or

Managing Director or a Director. The GBIC has the authority to appoint and terminate the services of Insurance Ombudsman. Persons selected to be Ombudsman should not be more than 62 years of age and have experience or have been exposed to the industry, civil services, administrative service etc. in addition to those drawn from judicial services. The appointment is for a term of three years or attaining the age 65 whichever is earlier. Reappointment is not permitted.[2]

At present there are seventeen ombudsman centres covering the whole of India. The ombudsman centres and their territorial jurisdiction are available in the website of GBIC.[3] The Ombudsman centres have staff appointed to assist the ombudsman in disposal of its duties. The Ombudsman is also assisted by professional experts from various fields like life insurance and non life insurance appointed on contractual basis for providing technical support (The summary of staff position is given in Table 01).[4]

System of Filing Complaints with Ombudsman

Complaints can be made by the policyholder (who has taken an insurance policy on personal lines i.e. policy taken and given in an individual capacity) / claimant / legal heir to the ombudsman and the procedure is as follow:

(i) The matters pertaining to which a complaint can be filed are:

- Partial or total repudiation of claims
- Delay in settlement of claims
- Dispute related to premiums paid/ payable
- Legal construction of polices in so far as such dispute relates to claims
- Non-issue of insurance documents.

(ii) The complainant should first write to the grievance redressal officer of the insurance company against which the complaint is being made. The insurance company should deal with the complaint within 30 days. If there is no response within this time or if the complainant is not satisfied with the response, then the person can approach the ombudsman and file the complaint.

(iii) It should be in writing duly signed by the complainant along with photocopies of supporting documents like:

- all pages of policy documents.
- repudiation/denial letter/partial settlement letter issued by the insurance company.
- representation made to the grievance redressal of insurance company.
- any other correspondence exchanged with the insurance company/TPA.
- copies of old policies covering insurance for last 48 months for claims rejected on ground of pre-existing disease or waiting period (health insurance).
- Hospital Bills, Investigation reports claim form, Indoor Case papers etc. for mediclaim / health insurance.
- RC Book, Driving License etc for Motor Complaint.
- Annexure VI-A i.e. Details of the complaint to be furnished to Ombudsman Office along with consent for Ombudsman to act as mediator (The format of the complaint form and Annexure VI-A is available on the website of the GBIC.) [5]

(iv) The value of the claim including expenses should not exceed ₹ 20 lakh.

(v) The complaint should be made within 1 year from the date of rejection / repudiation / partial settlement of claim by the insurer.

(vi) The complaint must be made as per the jurisdiction of the Ombudsman.

(vii) The same matter should not have been taken up to any other forum / courts / arbitrator.

Process of Dealing with a Complaint by the Ombudsman

The power of Ombudsman as defined in the RPG rules state that "The Ombudsman shall act as counselor and mediator in matters which are within his term of reference and, if requested to do so in writing by mutual agreement by the insured person and the insurance company". It also goes on to state that the decision, whether the complaint is fit and proper for being considered by it or not, is final.

Generally, any complaint made to an Ombudsman falls under two broad categories – entertainable or non-entertainable. Entertainable complaints are taken up by the ombudsman while the non-entertainable are not taken up. A complaint can be non-entertainable due to the following reasons:

- it can be beyond the scope of the rule or
- it does not fall within the jurisdiction of the ombudsman or
- the complainant has not availed grievance redressal mechanism of the insurance company against whom the complaint is filed or
- the matter of the complain can be sub-judice in courts/forums or
- the complaint can be time barred.

When the complaint is entertainable, the complaint can end up being disposed off as a recommendation or a withdrawal/ settlement or an award or an ex-gratia payment or a dismissal.

Recommendation / withdrawal / settlement: A complaint can be settled through mediation of the ombudsman undertaken by him in pursuance of request made in writing by complainant and insurer through mutual agreement. In such a scenario the ombudsman makes a recommendation which he thinks fair in the circumstances of the case and this recommendation is made not later than one month from the date of receipt of the complaint. If the complainant accepts the recommendation he should give his acceptance in writing within 15 days to the ombudsman stating clearly that the settlement is acceptable to him totally in full and final settlement of the complaints.

The ombudsman sends the recommendation along with the acceptance of the complainant to the insurer. The insurer should comply with the recommendation immediately not later than 15 days of the receipt and inform the ombudsman accordingly.

Award: When the complaint is not settled by agreement, the Ombudsman shall pass a speaking Award with detailed reasoning which he thinks fair in the fact and circumstances of a case. The award should be in writing and state the amount awarded to the complainant. The ombudsman shall pass an award within a period of three months from receipt of the complaint. A copy of the award will be sent to both the complainant and the insurer. The complainant should furnish to the insurer within a period of one month from the date of receipt of the award a letter of acceptance that the award is in full and final settlement of his claim. The insurer shall comply with the award within 15 days of receipt of the acceptance letter and shall intimate the compliance to the ombudsman.

Ex-gratia payment: If the ombudsman deems fit, may award an ex-gratia payment.

Dismissal: The ombudsman depending on the merit may dismiss the complaint and the verdict is treated in favour of the insurer.

Analysis of Insurance Ombudsman Scheme in India

The insurance ombudsman scheme has been since 1998. In the meantime a lot of change has taken place in the insurance industry as well as the economy. The best way to understand the working of ombudsman scheme is either through survey (which is very costly) or through analysis of secondary data. The most important source of secondary data is the Annual reports of GBIC and other information available in the website of GBIC. For the purpose of this paper analysis is done with the secondary data.

Source of data: The e-copy of the annual report of GBIC is used as the source of data.[6] The annual reports for the four financial years from 2012-13 to 2015-16 has been taken up for analysis. The main section of the annual report from where the data is used is the one which contains the complaint statistics and thirteen annexure. Some supporting data is also used from website of GBIC. The list of thirteen annexure used for collating data is as:

Sl.	Statement	Description
1	L1G1	Complaint disposal Centre wise - Life and General insurance (Total)
2	L2	Complaint disposal Centre wise - Life insurance
3	G2	Complaint disposal Centre wise - General insurance
4	L3	Complaint disposal Company wise - Life insurance
5	G3	Complaint disposal Company wise - General insurance
6	L4G4	Details of Awards & Recommendation Centre wise - Life & General Insurance (Total)
7	L5	Details of Awards & Recommendation Company wise - Life insurance
8	G5	Details of Awards & Recommendation Company wise - General insurance
9	L7G7	Nature wise-Centre wise complaints received - Life & General Insurance (Total)
10	L8	Nature wise-Centre wise complaints received - Life Insurance
11	G8	Nature wise-Centre wise complaints received - General Insurance
12	L9	Nature wise-Company wise complaints received - Life Insurance
13	G9	Nature wise-Company wise complaints received - General Insurance

The Methodology: The data from the annual report was first physically entered in excel format prepared according to the above thirteen annexure. The data were subsequently analysed using MS-excel. Averages, percentages were the main mode of statistics extracted.

Disclaimer: All care was taken to enter the data as meticulously as possible in excel sheet on basis of which analysis were carried out. Fifty two formats were filled up, if any error in output arise it may be due to error in data entry.

Overall Working of Ombudsman Scheme in 2015-16

The annual reports of 2015-16 was used to study four broad subjects: (a) disposal of complaints and time line, (b) nature wise complaints received, (c) Human resources assisting ombudsman and (d) Revenue and expenditure.

Disposal of Complaints and Time Line

There were seventeen ombudsman centres functioning in 2015-16.[7] However, in some of the centres the post of ombudsman was vacant; in two centres (Ahmadabad and Guwahati) for the full year and one centre (Chandigarh) for part of the year. In Ahmadabad centre ombudsman from Pune, Chennai, Patna and Bengaluru carried out monthly hearings, while the hearing of Guwahati centre was carried by ombudsman Kolkata. In Chandigarh centre for part of the year hearings were carried out by ombudsman from Bengaluru, Chennai and Delhi.

During the year total 26177 complaints were received and total 30266 were disposed. Thus, the outstanding complaints as on 31.03.2016 came down to 2693 compared to 6782 as on 31.03.2015 (Table T-1). Almost 50%[8] of the complaints disposed were by the method of "not-entertainment" as these complaints were disqualified on grounds like "complainant not availing insurer's grievance redressal mechanism before approaching ombudsman", "the complaints being outside the scope of rule", "not within jurisdiction", "sub-judice" or "time barred". Of the remaining some were disposed as award/recommendation in favour of the policyholder (29%)[8], dismissals which were in favour of insurers (12%)[8] or through withdrawal/settlement (10%)[8]. Out of all the complaints that were disposed 12378[9] complaints resulted in award and recommendation amounting to ₹ 56.30 Crore[9]. Off the total award/ recommendation of 12378 the ratio of life to general was around 60:40, while the amount awarded/recommended was in the ratio of around 70:30. [9] Thus, the amount awarded /recommended per case was higher for life and stood around ₹ 55,087 compared to ₹ 31,417 for general insurance business[9].

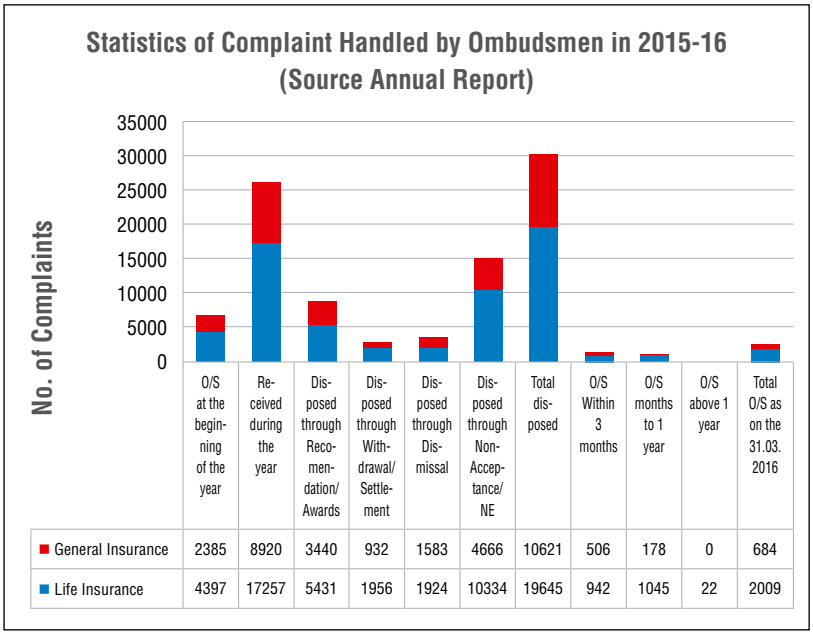
From "Chart A", we see that around 2/3rd of the complaints received and disposed pertain to life insurance while balance 1/3rd pertains to General insurance. Two out of three outstanding complaints at the beginning of the year were from life insurance and it increased to 3 out of 4 outstanding complaints by the end of the year.

Out of all the complaints disposed, 20703 (68%) were disposed within 3 months while 6649 complaints were disposed within a period of 3 months to 6 months and remaining 2914 were disposed after 1 year from the date of receipt.[8] From the Annual report the neither the exact distribution of time taken for disposal of complaints nor the average time taken for disposal is known. As per Table T-2, the estimated average time for disposal of a complaint comes to around 124 days.

Though 68 percent of the complaints were disposed within 3 months, around 50% out of these 68% (i.e. 15000 complaints) required only basic

Chart – A

Breakup of Complaints Handled by Insurance Ombudsmen in 2015-16



processing as these were non-entertainable.[7] Let us assume that non-entertainable complaints can be disposed in 15 days (on an average) as it does not require much lengthy processing. We get the data for entertainable complaints which are shown in Table T-3. Now, we find that the average time for disposal of an entertainable complaint in Table T-3 and it comes to 195 days.

Those complaints which could not be disposed remains outstanding at the end of the year and there were 2693 such complaints. Out of 2693 complaints that were outstanding, 1448 were within a period of 3 months, 1223 were pending between 3 to 6 months and 22 were pending for more than 1 year.[7] Around 85% of the complaints which are outstanding and pending for more than 3 months are from life insurance (Chart A).

Nature-wise Complaints

From Statement L7G7 of Annual report of GBIC for the year 2015-16 and Table 4 we observe that out of the 26177 complaints[10] received by the ombudsmen, 15000 (57%) were non-entertainable[10] due to various reasons, while 11177 (43%) were entertained[10] based on the five matters on which a complaint can be filed with an ombudsman. Twenty seven percent of the complaints received by the ombudsman were not entertained as the complainant had not availed the grievance redressal mechanism of the insurer while one out of five reported complaints were not entertained as they did not fall within the scope of the rule and around 9% of reported complaints did not fall within the jurisdiction of the ombudsman. These three reasons constituted to 96% of the total non-entertainable complaints. About 60% of the total life insurance complaints received by the ombudsman are non-entertainable, while one out of two general insurance complaints is entertainable. The reasons for non-entertainment are more or less the same for life and general as already explained above.

From Table T-4, we see that one out of 4 complaints reported to the ombudsman were due to partial/total repudiation of claims, while 16% of the reported complaints pertained to dispute regarding premium paid or payable in terms of policy. These two reasons contributed to 95% of the entertainable complaints.

From data of statement L8 and G8 we find that forty two percent of all general insurance disputes referred to the ombudsman related to partial/total repudiation of claims higher than the overall insurance industry average and 4 percent relates to dispute in regard to premium payable and premium paid. On the other hand dispute regards premium paid or payable in life insurance constitute 23% of the total life insurance dispute and repudiation constitutes another 15%.

> The average time for disposal of complaints is an important benchmark for ombudsman scheme. From the estimated time for disposed complaints we find that it takes on an average 124 days to do so, which is around 4 months. The timeline can be decreased, and in future with engagement of more resources it may come down.

Human Resources Assisting Ombudsman

The actual number of staff members assisting the ombudsman could not be ascertained from the annual report. The number of staff as on 31.03.2017 assisting the various ombudsmen at different centres stood at 120 (Table O1) of which 72 staff members are on deputation from organisation like LIC (54), NIC (6), OIC (5), NIA (4), UIIC (2) and IRDAI (1). Forty eight professionals are engaged as expert from life insurance and non-life insurance. Ten persons are with GBIC office.

During the year 2015-16, retired officials from Public Sector General Insurance Companies were engaged as professional experts on contractual basis in the various offices of the insurance ombudsman after going through due process of selection. Similar exercise was planned for life insurance sector in the year 2016-17. Assuming that the number of staff on deputation as on 31.03.2016 were same as on 31.03.2017, and the fact that only experts in non-life were recruited in 2015-16, the staff assisting various ombudsmen as on 31.03.2016 comes to 96. Based on the derived staff strength as on 31.03.2016, on an average 315 complaints were disposed per staff in 2015-16.

Revenue and Expenditure

The total annual expense of the ombudsmen scheme in 2015-16 was ₹ 32.58 Crore. The expenses were financed by the members of GBIC through a mechanism of pro rata

contribution based on the gross premium income of the preceding year. Based on the expense figure and number of complaints disposed we see that on an average ₹ 10,766 was spent towards disposal of a complaint.

Inference Based on the Analysis of Working of Ombudsman Scheme in 2015-16

1. The substantial decrease in the number of outstanding complaints as on 31.03.2016 compared to previous years can be correlated to the increase in the staffing of the ombudsman centres. The number of staff increased by at least 24 people (general insurance professional engaged).
2. The engagement of experts in field of general insurance has not only added to quantitative aspect of human resources but also the qualitative aspect. This is seen from the fact that as on 31.03.2015 the reduction of outstanding complaints was more for general insurance (71%) compared to life insurance (54%).
3. The average time for disposal of complaints is an important benchmark for ombudsman scheme. From the estimated time for disposed complaints we find that it takes on an average 124 days to do so, which is around 4 months. The timeline can be decreased, and in future with engagement of more resources it may come down.
4. Though an estimated average 4 months are taken to dispose a complaint, if we focus on entertainable complaints this time increases to six and a half month. The scheme envisages that a complaint disposed by recommendation must be within 1 month and if disposed through award it should be within 3 months. This average time will come down in future due to the planned increase in the human resources of the ombudsman especially in life insurance, where the average time for disposal of entertainable complaint is even higher (around 7 months compared to 6 month for general insurance).
5. Among the major reasons for a complaint being not entertained by the ombudsman was that the complainant had not availed the grievance redressal mechanism of the insurer (around 50% of the non-entertainable cases). From a customer's perspective it is sometimes more realistic to complain first to the ombudsman on being aggrieved than the insurer, as external or third party is perceived to do more justice while handling a grievance and command greater trust. This phenomenon of complainant approaching ombudsman before insurer shows that the policyholders are aware of ombudsman scheme but probably do not know the rule that they must first avail the redressal mechanism of insurer. Hence, in the policy document not only the address of the ombudsman but also the basic rule of approaching ombudsman after approaching the insurer should be highlighted.

Trends Observed in Insurance Ombudsman Scheme

In the previous section we have seen the functioning of the ombudsman scheme in 2015-16. In order to understand the pattern of complaints, disposal, nature, awards etc. over a period of time we will take the help of trend analysis. Another reason why trend analysis is important is that it irons out the fluctuations. For better trend analysis data over a longer period of time, say a decade, is always useful. Only four year data is available and it may not be possible to ascertain any perceptible trends, yet an attempt is made in this section to understand working of the system.

Disposal of Complaints and Time Line

It is observed from the table "T-1: Trend of disposal of complaints received", that over the years the disposal ratio (i.e. ratio of number of complaints disposed in a year to the number of complaints received in the year) has increased consistently. Since 2014-15 the disposal ratio is more than 1, thus leading to decrease in the number of outstanding complaints at the end of year. The outstanding complaints after increasing slightly in 2013-14 (as disposal ratio then was less than 1) has thereafter declined substantially from 8601 in 2012-13 to 2693 in 2015-16.

We have already discussed in the previous section that average time for disposal of a complaint, especially entertainable complaints is a significant benchmark of the working of the ombudsmen scheme. In table T-2 and we find that the average number of days for disposal of a complaint has increased during the year 2012-13 to 2014-15 and then dipped in 2015-16. The average time for disposal of an entertainable complaint also rose during the year 2012-13 to 2014-15 and fell to the lowest level of 195 days in 2015-16 (table T-3). Thus, the trend of increase in average disposal time was not only reversed in 2015-16 but also reduced significantly attaining lowest level in four years.

The average time that a complaint has remained unresolved and outstanding on 31st March fluctuates with no perceivable trend. However, it is at its lowest of 130 days in 2015-16 (table T-2A).

Inference: There has been a remarkable improvement in the working of the insurance ombudsman scheme over the past 4 years. The disposal rate has increased which has lead to a significant decline in outstanding complaints. Even the average time to dispose complaint especially entertainable complaints has dropped down substantially and it is at a four year low. However, there is much scope for improvement in this aspect as section 3 of the RPG rule has efficiency as one of the objective of this scheme.

Nature Wise Complaints

From Table "T-4: Trend of Nature wise complaints received", we find some interesting trends. The percentage of non-entertainable complaints shows continuous decline over the four years from 65% in 2012-13 to 57% in 2015-16. Within this segment the main reason for non-entertainment for all years is that the complainant has not availed of the grievance redressal mechanism of insurer. However, every successive year the percentage of such complaints has declined and fell from 41% to 27%. Complaints not entertained for being sub-judice or time barred is substantially low at 1 to 2 percent of the total. However, one reason for non-entertainment which has seen rise over the years is that the complaints are not within the jurisdiction. Such complaints have rose from 4% in 2012-13 to 9% in 2015-16.

The trend of more complaints being entertained by ombudsmen is seen from table T-4. From only 35% of the total complaints being entertained in 2012-13 the percentage rose to 43% in 2015-16. The major ground on which a complaint is entertained every year is due to partial or total repudiation of claim. The complaint entertained on this ground has shown steady increase from 20% to 24% in four years. Complaints entertained on grounds of dispute regarding premium paid and premium payable also increased from 9% to 16% during the same period. Other reasons for entertainment of complaints are substantially low at 1 to 3%.

From Table T-4A and T-4B, we find the nature of complaints entertained from life insurance industry and non-life industry reveals distinct trends. In life insurance industry dispute regarding premium paid and premium payable is the major source of entertainable complaints and over the year it has rose from 14% to 23%, while repudiation of claims comes next which has increased from 8% to 15%. On the other hand, in non-life insurance industry partial / total repudiation of claims is the major cause for complaints and it is in the range of 41 to 45% , while dispute related to premium paid and payable comes way behind ranging between 1 to 4%.

Inference: What is again more pleasing to see is that the percentage of entertainable complaints has increased over the years. This indicates that the complainants have become more aware of the rules of filing complaints with ombudsman. One more reasons which can be inferred for rise in entertainable complaint is that those complainants whose application are not entertained by ombudsman in a year, on the ground that they have not availed of the grievance redressal mechanism of insurers, approach subsequently to ombudsman after going through the process of insurer. This is indicated by the fact that the percentage of non-entertainment on the ground on non-utilisation of insurer's grievance redressal process has declined over the years.

The partial/total repudiation of claims along with disputes with regard to premium paid and payable is a major reason for complaints to the ombudsmen. The increasing trend in the percentage of such complaints being entertained means more such cases are being reported correctly as per rules. The distinct trend between life and non-life insurance can easily be explained based on the nature of business. In non-life the incidence of claim becomes disputable due to the nature of business which includes health insurance. It also includes other insurances like motor, fire, miscellaneous where third party like TPA and Surveyor are involved. In life insurance in most cases it is binary decision (payment or non-payment) related death claim. In non-life it involves loss assessment as well as application of exclusions, co-payment, sub-limit etc.

The dispute regarding premium paid and payable is the major cause in life due to the long term contract of the insurance policies as well as mis-selling of non-single as single for higher commission rates. Such instances are lesser in non life.

Human Resource

The data pertaining to number of staff employed during the various years could not be ascertained for the different years and hence it was not possible to ascertain any trend related to human resources or the complaint disposal rate.

Revenue and Expenditure

From Table "T-5: Costing of ombudsman scheme", we observe that the complaints disposed have grown by 30% while consolidated expenses of ombudsman scheme has grown by 122% during the year 2012-13 and 2015-16. This has resulted in an increase in cost of disposal per complaint from ₹ 6,283 in 2012-13 to ₹ 10,766 in 2015-16. Thus, the cost of disposing one complaint is costing 71% more in 2015-16 than what it cost in 2012-13.

If we see year on year (YoY) growth of the expenses, we find that in 2013-14 and 2014-15 the growth is 11 to 18%, while in 2015-16 there is a substantial jump in expenses and the growth is around 70%. This jump of 70% has resulted in substantial jump in the cost of disposal of a complaint in the year 2015-16. If we consider the YoY growth of cost of disposing a complaint we find that for 2013-14 there is a nominal growth of 3%, in 2014-15 there is a growth of 22%, while in 2015-16 there is a growth of 36%.

On the revenue side, as already discussed, the insurers (members of GBIC) contribute towards the expense of the ombudsman scheme based on the market share of their gross premium income. From the annual report of GBIC for 2015-16, we see that one of the observations of insurance ombudsman – Mumbai is that the number of complaints coming from companies with smaller policy base and premium income is disproportionate to their market share. Thus, his suggestion is that the cost sharing method among the members of GBIC needs to be relooked and cost should be shared based on the proportion of the complaints with a provision for discount in case a complaint is resolved within 15 days of lodging with the ombudsman.

The data of Total premium income of life insurer and Gross direct premium of non-life insurer available in Table 3 and Table 45 of annual statistics of IRDAI along with complaints statistics available in statement L3 and G3 of Annual report of GBIC is consolidated for the year 2012-13 to 2015-16 and compiled in Table-6. The consolidation for four years was done to rule out fluctuations in a single year.

From Table-6, we observe that the share of complaints of an insurer to the total complaints (which is a cost to the ombudsman scheme) and share of revenue contributed to ombudsman scheme to the total revenue (based on gross premium income) is not matching. There are 35 entity whose ratio of contribution towards cost (share of complaints) to contribution towards revenue (market share of premium) is as higher than 1.

Inference: The cost of disposal of a complaint has seen a steep rise in the four years. The maximum rise has been during 2015-16 of around ₹ 3000 per complaints. The main reason which can be attributed to this is the increase in cost of manpower engaged. There has been a substantial increase in the salary cost of the existing staff as can be seen from the income and expenditure accounts for the year ended 31.03.2016 in the Annual Report of GBIC. Besides this, during 2015-16, 24 professional experts in non life insurance were engaged. The monthly remuneration paid to them ranged from 30,000 to 45,000 (based on last designation of their job).[11]

The method of financing the ombudsman scheme also needs to be relooked in light of the observation and suggestion made by insurance ombudsman Mumbai.

Movement of Complaints from Insurer to Ombudsman

The ombudsman scheme is a second tier of grievance redressal in insurance industry. When a policyholder is aggrieved s/he approaches the insurer for redressal and if not satisfied, then they may or may not approach ombudsman. However, there are instances where the aggrieved policyholder approaches the ombudsman directly as seen from the data of nature wise analysis of complaints (statement L7G7 of AR of ombudsman).

In table "T-7: Movement of complaints from insurers to ombudsman", we have tried to analysis the movement of complaints of policyholder to the insurers and then to the ombudsmen. The cumulative data of complaints resolved by the insurer for four years from 2011-12 to 2014-15 is taken from Table 3 and 45 of IRDAI annual statistics for the years from 2011-12 to 2014-15. The cumulative data of complaints made to ombudsman from 2012-13 to 2015-16, is taken from statement L3 and G3 of AR of GBIC from 2012-13 to 2015-16. The data of complaints made to the ombudsman is taken for equal period but with one year lag because it is assumed that after resolution of complaints by the insurer the complainants approach the ombudsman which may take some time and the lag is assumed to be one year.

This comparative analysis gives us a fair indicator and not the exact picture of the movement of complaints because complaints made to ombudsman is only a small subset of the total complaints made to the insurers. For example, complaints made to insurers can cover areas of mis-selling, servicing aspect like loans, assignments, nominations, behaviour of staff, ambience, facilities and any perceivable reasons, while complaints made to ombudsman are clearly defined and fall under five heads.

It is observed from table T-7 that, out of around 15.92 lakhs complaint resolved by the insurers in four years 66.46 thousand (4.17%) is reported to the ombudsman in the subsequent four years, out of which around 38.41

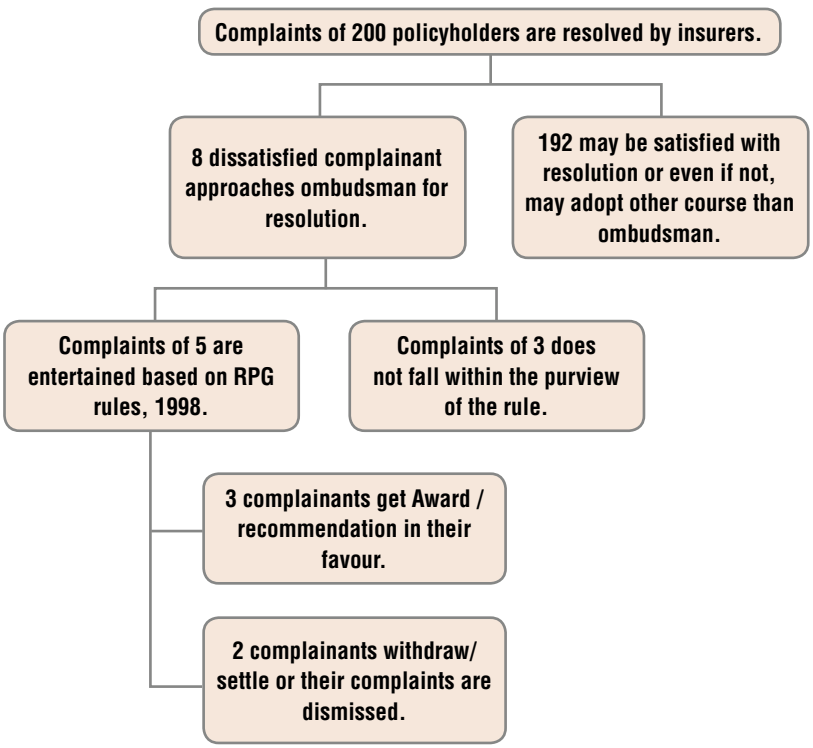
thousand complaints (58%) are found to be entertainable out of which around 21.28 thousand (55%) results in awards and recommendations favouring policyholder. Thus, on an average out of around 200 policyholder whose complaints are resolved by the insurers, 8 knocks the door of ombudsman out which complaints of 5 are entertained on basis of ombudsman rules and 3 get an award / recommendation in their favour.

The pattern is not uniform but varies across insurers and type of insurance company. Any further inference can only be based on further analysis and availability of more data which is beyond the scope of this paper. The graphic presentation of the movement of complaints is shown in the chart B below:

Inference: From the data of movement of claims in Table T-7 and illustration in "Chart A" we see that the complainant dissatisfied with complaint resolution of insurers is 4.17% which is not a very high number. But, the grievance reported to ombudsman form only a part of the types reported to insurer. If data of complaints resolved by insurer for the five types reported which are reported to ombudsman is available and it is used for calculation, then this percentage will be much higher. Thus, 4.17% is the lower boundary of the estimate of dis satisfied complainants. The decisions in favour of complainants by means of awards / recommendation out of entertainable complaints shows that the grievance redressal mechanism of the insurer is doing quantitative job of disposal and not the qualitative job of redressal.

"Chart B"

The movement of complaints illustrated with an average of 200 policyholders whose complaints are resolved by insurers



Ombudsman System – A Global Overview

The system of ombudsman is a form of alternative dispute resolution, commonly known as external dispute resolution (EDR). There are a number of external ombudsmen in different countries of the world. The system of ombudsman can cover a wide gamut of services like financial services (banking, insurance, mortgages etc), public administration, justice system, human rights etc. There are a number of associations of independent external ombudsmen around the world namely International Ombudsman Institute (IOI), International Network Financial Services Ombudsman Scheme (INFO network), FIN-NET (European Economic Area), United States Ombudsman Association (USOA), The Ombudsman Association, Australian and New Zealand Ombudsman Association (ANZOA) and Forum of Canadian Ombudsman (FCO).[12]

The International Network of Financial Services Ombudsman Scheme (INFO network) is an important association mainly dealing with financial services like banking, investments, insurance, credit, financial advice, pensions/ superannuation and other financial services. INFO network was set up in 2007 with objective of developing expertise in dispute resolution by exchanging experiences and information. There are 58 ombudsmen of 37 countries spanning 4 regions as members of this association. The Banking Ombudsman of the Reserve Bank of India is the lone member of the association from India[13].

International Principles of Financial Services Ombudsman (INFO Network)

The INFO network lays down six fundamental principles to which its members should aspire and try to adopt effective approaches (EA) to these principles. The network does not set compulsory standards for its members keeping in mind the various constraints that can be faced by them. However, it expects the members to aspire to comply and helps them to do so. The six fundamental principles laid down by INFO network are -

- independence, to secure impartiality
- clarity of scope and powers
- accessibility
- effectiveness
- fairness
- transparency and accountability

GBIC is not a member of this association. Thus, technically it is not expected to adopt the standards or principles which are prescribed by INFO network for its members. However, in the following section an academic exercise of comparing the Indian insurance ombudsman system vis-a-vis internationally accepted principle of INFO network is carried out. This is done to ascertain the level of standards adopted here and understand difference if any. The effective approaches as described in INFO network's website in the e-booklet named "INFO Network: Effective approaches to fundamental principle" available at http://www.networkfso.org/about-ombudsmen.html is used for this exercise. The summary of outcome of comparison exercise carried out is given in the subsequent sections.

The approach adopted is to check how much compatible is the working of Indian insurance ombudsman scheme with the effective approaches described in the e-booklet of INFO network. It is important to note that all data for exactly verifying the compatibility is beyond the scope of this paper. However, the broad working as known to us as a policyholder or insurance profession is used to check the compatibility. As a fundamental disclaimer it is stated that even INFO network states that adoption of effective approaches is contextual to the country and varies across economy and culture.

Principle: Independence, to Secure Impartiality

This is an important principle which lends credibility to the institution of ombudsman. Since, the institution of ombudsman acts as an impartial and external dispute resolution mechanism the aggrieved party approaching it must have confidence that it will act independently and impartially. On the other hand the party against whom complaints are made must also have same confidence that the institution is independent and impartial. There are three sub-principles of the main principle of independence, which are:

- They should be (and also be seen to be) independent and impartial – resolving cases on their merits, without fear or favour.
- Financial ombudsman schemes should be established so that they are visibly and demonstrably independent of both the financial industry and consumer bodies.
- Decision-makers should be free from influence/direction – including free from influence / direction by parties to disputes, regulators and governments.

The effective approaches as suggested by network towards adherence to this principle include ways to impart independence mainly established in law or in a constitution approved by public-interest agency. The ways of resolving cases, appointment and terms of services, staff and resources made available to ombudsman and an independent governance body are suggested as part of the approach. The Insurance ombudsman scheme in India as compared with the effective approaches mentioned in e-booklet was done.

It is seen that the Indian insurance Ombudsman scheme is in line with all the approaches except for some approaches suggested for independent governance body. More specifically, the membership of the Governance body or GBIC is only limited to the insurers and hence representation of consumer bodies is desirable. Though, the approaches towards governance body of Indian insurance ombudsman scheme are an area for consideration. Yet, in its present form the governance structure does not affect the principle of Independence.

Principles: Clarity of Scope and Powers

The second principle dealing with clarity and powers guides the ombudsman to publish details of:

- the scope of its jurisdiction;
- its enquiry and case-handling processes;
- its powers;
- the status of its decisions;
- any effect on the complainant's legal rights of using the ombudsman scheme; and
- the information which is (or is not) kept confidential.

After comparison with the effective approaches mentioned in the referred e-booklet, we observe that the Indian

insurance ombudsman scheme through the website of GBIC has disclosed all that that is required. For example the scope of its jurisdiction, its enquiry and case-handling processes; its powers are clearly spelled out in the RPG rules 1998 which is available in the website. The status of the decisions is available in the website at http://www.gbic.co.in/synopsis.html . Any effect on the complainant's legal rights of using the ombudsman scheme is also answered through FAQ as well as mentioned in the RPG rules. The confidentiality of the information is subject to the provision of Right to Information Act. Thus, the scheme confirms to the principle of clarity and scope and powers.

Principle: Accessibility

The principle of accessibility primarily ensures that the financial business entity provides the detailed information about the ombudsman scheme to all its customers. Besides this, there should be a mechanism to ensure that the system is widely publicised by the ombudsman itself. The scheme must be easily accessible without barrier to cost and make appropriate provision for vulnerable complaints. Here the effective approaches deal with the information dissemination process by the business entity, ombudsman and other sources. The modalities of communication with the ombudsman, cost involved and the free choice of the complainant to avail other legal system of grievance redressal are the other effective approaches outlined.

The regulatory requirement mandates dissemination of information about the scheme by insurers at the time of issuance of contract as well as during communication of decisions related to a dispute. The GBIC itself has all the information in its websites while the ombudsman at various centres carries out various publicity activities like Bima lokpal day which are also supplemented by the regulator through various awareness and publicity campaigns. The scheme is free of cost for the policyholder and the right to approach other forum if not satisfied is always with the complainant.

However, there is some scope of improvement in complying with the requirement of receiving complaints online, which is also required in the present context. Now, only written complaints are handled as formal request. In the present era feasibility of electronic form of complaints filing, referral to insurers, video-conferencing for disposal of complaints etc can go a long way to reduce cost and enhance efficiency of the scheme. Other than this the scheme is in complete sync with the principle of accessibility.

Principle: Effectiveness

The approaches to comply with the principle of effectiveness stress on obligations for the business entity a mechanism to deal with complaints and system of redressal through Ombudsman. The Ombudsman scheme itself has informal and flexible process and also provide requisite information, advice and training. The Ombudsman office should be having adequate resources and the knowledge and skill of the decision maker is also important.

The principle of effectiveness guides that in an Ombudsman system there should be a clear definition of what constitutes a complaint; and clear obligations on financial businesses to deal with complaints fairly and promptly. The scheme has a flexible and informal process (where parties do not need professional advisers).

It is seen that the Indian insurance industry has a well defined internal grievance redressal mechanism of the insurers as part of regulatory requirements. In fact the internal systems of insurer are linked with the regulatory system of Integrated Grievance Management System (IGMS) which acts as a database of complaints of the insurance industry. The ombudsman system has informal and flexible system of dispute resolution. The complainant do not require professionals like lawyers or accountants to deal with their cases.

The insurers are expected to comply with the orders promptly. The regulator (IRDAI) vide their communication Ref: IRDAI/CAD/CIR/MISC/063/03/2016 dated 31.03.2016 have instructed the insurers to comply with the decision within the time frame of the award and if no time is mentioned then within 60 days of receipt of order. The expertise of ombudsman and knowledge and expertise level of the staff assisting is also of high order. The system is adequately staffed and even experts are now engaged. Thus, the system passes the test of principle of effectiveness.

Principle: Fairness

This principle of fairness envisages that ombudsman scheme should be prompt, impartial, proceed fairly and tell the parties in writing it decision for it. The effective approach for this principles ensures that at the outset the implication of decisions are explained, due process is followed and disputes not handled due to jurisdiction etc are informed properly so that the complainant can take due recourse. The ombudsmen deal with the complaint promptly and reach the decision impartially.

All these are followed in the Indian ombudsmen scheme. However, dealing with the complaints promptly is a subjective matter and internal benchmarking is required commensurate with the resources. In this context the time taken for disposing the complaint has scope for improvement. The matter is dependent on various infrastructure issues and it is being addressed with recruitment of experts which has led to reduction in average time required to dispose a complaint, thus ensuring promptness. As already seen in the Analysis section the average time for disposal especially of entertainable complaints has come down significantly.

Principle: Transparency and Accountability

This principle envisages that the scheme pay due regard to the overall public interest in forward-planning and day-to-day operations; consult publicly about their scope, procedures, business plans and budgets; and publish a report at least yearly, explaining the work that they have done.

In context of the Indian system, forward planning is done and business plans drawn along with the budget. The same is limited within GBIC and the ombudsman centres and not done in public. However, the annual report is published yearly explaining the work done with the statistics of the complaints handled and disposed. The finance i.e. income and expenditures as well as the balance sheet is published in with the annual report.

Here, we find that the annual report published by GBIC is very basic and gives only primary information. The report does not contain benchmarks, achievement vis-a-vis these bench marks. Analysis of the data, and scenarios is not available in the annual report. The public is thus able to see what is happening without making any sense of why it is happening and how issues facing the system are going to be addressed in the future. But still, the scheme is compatible with the principle of transparency and accountability.

Inference from Application of Principles of INFO Network to Indian Insurance Ombudsman Scheme

What we observe from the preceding section is that the insurance ombudsman scheme based on RPG rules of 1998 is compatible with all the principles of INFO network. In few cases of effective approach there is scope for progress but it is a matter which may require changes in the rules. However, it is high time that the scheme is revisited and loopholes are plugged and made in tune with the present time. Thus, the standard in terms of application of principles, by the Indian insurance ombudsman scheme can be said to at par with international level.

> The principle of effectiveness guides that in an Ombudsman system there should be a clear definition of what constitutes a complaint; and clear obligations on financial businesses to deal with complaints fairly and promptly. The scheme has a flexible and informal process.

Study of Insurance Ombudsman Scheme of United Kingdom and Taiwan

An attempt is made to get an overview of financial ombudsman scheme (especially insurance ombudsman) of other countries to understand and know the best practices. The learning can be used as a guideline for development of Indian insurance ombudsman scheme. It will also help to identify areas for improvement and adoption of internationally accepted best practices.

Financial Ombudsman Service of United Kingdom (FOS-UK)

In United Kingdom there is one ombudsman for financial services known as Financial Ombudsman Service (FOS) and it was set up under the Financial Services and Markets Act 2000 of UK. The objective is to resolve individual disputes between consumers and financial businesses – fairly, reasonably, quickly and informally .The various financial services like insurance, credit, banking, savings and investments come under its purview. From the annual report of FOS-UK, we get a vivid picture of the working of the scheme. There are around 3676 staff members and the service has an annual budget of 257.9 million pounds. The services are free to consumers and the funding is through combination of annual levies on the financial business covered and fees for individual complaints referred to us by each user.

It has a system of handling queries and complaints and in 2015-16 it handled around 16.32 lakhs queries averaging over 5000 each working day. Half of these enquiries were over phone and half through written mode including e-mails. Half of the people who enquired but did not make formal complaints went on to tackle the problem

themselves and ninety percent of these people said that the help and advice of FOS-UK helped them. Thus, the system of receiving enquiries and handling them qualitatively helps in addressing concerns of the consumers even before making a formal complaint. One out of five enquiries resulted in detailed investigations and thus, 3,40,899 new complaints were reported in 2015-16. The FOS-UK was able to close 4,38,802 including outstanding of previous years.

The complaints can be made by the consumers themselves or by claims management companies, free consumer advice agencies, professionals like lawyers and accountants and friend and family members on behalf of the consumers. For complaints related to services like bank accounts and Payment Protection Insurance (PPI); more than 60% were reported through claims management companies while for others, more than 80% cases were reported by the consumers alone.

Out of the complaints reported 2,19,996 complaints pertained to the insurance sector. In U.K. the complaints pertaining to insurance sector is dominated by Payment Protection Insurance (PPI) which contributes to around 86% of the insurance complaints. The other top three are motor insurance (3.85%), building insurance (1.82%), and Term insurance (1.05%). The balance around seven percent is shared within sixteen other line of business and each contributing less than one percent individually. Cause wise analysis shows that eighty eight percent of the complaints are as a result of sales and advice while eight percent is due to claims issues. Balance is due to administration (3%) and others (1%). The main reason for grievance in insurance industry of UK was the quality of communication, either at sales, subsequent or claim stages.

In general fifty one percent complaints were upheld meaning that the decision went in favour of complainants. However, for the insurance complaints 66% for PPI, for motor insurance and content insurance (33% each), for buildings insurance (38%), for travel insurance (48%) and twenty nine percent for health insurance were upheld. On a complaint being upheld, FOS-UK can tell the business to pay a specific amount of money up to one hundred fifty thousand pounds or/ and ask the business to set things right.

The PPI complaints which have taken alarming proportion due to systemic issue is the main cause in delay of disposal of complaints. In general 38% of the complaints were resolved within 3 months which included PPI. Without PPI, 66% of complaints were resolved within three months, while seventy five percent of motor insurance complaints were resolved within this period. PPI take a longer time for disposal and only 18% gets resolved within three months.

Keeping pace with changing time, the FOS-UK has increased its activities through online medium. During the year more than 50,000 people complained online, without going through the process of filling up forms and sending through post or e-mail. FOS-UK engages people across social media through Twitter, Facebook and LinkedIn. The official Twitter account of FOS-UK @financialombuds (https://twitter.com/financialombuds?lang=en) was mentioned tens of thousands of times and people even used it for sharing problems and asking for advice. People also reported their problems through the Facebook page available at https://www.facebook.com/financialombuds/. It was also used to disseminate information and receive enquiries. The internet page of FOS-UK http://www.financial-ombudsman.org.uk/ had nearly 7000 visitors every day in 2015-16.

Financial Ombudsman Institution – Taiwan (FOI-Taiwan)

The Financial Ombudsman Institution of Taiwan was established under the Financial Consumer Protection Act (FCPA) in 2011and commenced operation on 2 January 2012. The objective of FOI-Taiwan is to enable the efficient resolution of conflicts between financial consumers and financial institutions and to implement education and awareness programs for financial consumers, so as to reinforce the confidence of financial consumers in financial institutions and facilitate the sound development of the financial markets. From the annual report of FOI- Taiwan we get a glimpse of how the system is working in one of the most advanced insurance markets with a penetration of nineteen percent.[14] There are 63 employees on an average aged 39 years. The services to the consumers are free of cost and the scheme is totally government funded.

From 02.01.2015 to 31.12.2015, FOI-Taiwan handled 14996 cases which included 8352 advisory cases, 4434 complaints, 2096 ombudsman cases and 114 other cases. The exact break up for insurance and non insurance disputes is not available. However, from the major types of disputes in insurance claim it seen that medical necessity and claims amount constitutes around 23% of life insurance claims dispute. While determination of claims amount and degree of disability constitutes around 40% of property and casualty claims complaints. Disputes related to solicitation in life insurance constitutes to around 30% of non claim dispute while policy renewal in property and casualty is major non claim dispute with

33% of the cases. One of the important aspects of FOI – Taiwan is that it also addresses disputes related to insurance intermediaries. Dispute related to solicitation is a major cause with around 72% complaints.

One of the major highlights of the system is the average time take for disposing a complaint. The benchmark of the scheme is that FOI must render an ombudsman decision within 3 months after accepting an ombudsman case. The deadline may be extended by 2 months at most. Compared against this benchmark the average time to close a complaint is 45.23 days. Ninety five percent of the cases are closed within three months and since 2013 no case has taken longer than 5 months. Disputes resolved through mediation increased substantially and around 538 were resolved through mediation. The overall dispute resolution rate of FOI is 53% in 2015. Ninety percent of applicants whose disputes were resolved and 76% of those with unresolved applications were satisfied or very satisfied with the service.

Suggestions for Improving EDR in Indian Insurance Industry

Based on the previous sections we summarise here what can be done to improve the External dispute resolution (EDR) or more commonly the insurance ombudsman scheme in India.

- Revisiting the RPG, rules 1998 which are around two decades old and carrying out necessary changes to align with current aspiration of consumers as well as future expectation. For example the maximum limit for the amount under dispute which an ombudsman can entertain was ₹ 20 lakh in 1998 and still continues to be ₹ 20 lakh. A simple back of envelope calculation shows that at 5% appreciation the value of ₹ 20 lakh in 1998 becomes 50 lakh today. Thus, it is time to revisit the limit of 20 lakhs.
- In 1998 insurance market was monopolistic and basic vanilla life insurance products like term insurance were not sold much. Now term life has become an important product and most insurers have average sum assured more than 20 lakhs. Thus, the limit of 20 lakhs excludes one section of consumer from the ombudsman scheme. This aspect of high sum assured term insurance products should also be looked into.
- For disposal of complaints promptly and cost-effectively online system should be adopted. There should be online forms for lodging a complaint. The necessary changes in rules can be made to allow online system of filing complaints. In this regard a system like FOS-UK can be studied, developed and remodelled to be used as per Indian context. Such system when integrated with the IGMS of IRDAI will reduce and can even avoid non-entertainment of complaints on ground that the complainant did not use the dispute resolution of insurers. With the initiatives of GOI like Digital India the time is ripe for introduction of such system.
- The system of financing the ombudsman scheme needs to be revisited in light of the observation of insurance ombudsman Mumbai. Here again, a rational and fair system would be like the FOS-UK model, where combination of annual levies (may be based on gross premium income as in the current system) and fees for individual complaints referred. This will also force the insurer to strengthen their internal grievance redressal.
- There are instructions and circulars for prompt compliance of orders of ombudsman as discussed in earlier section, yet delay occurs in complying with the award and recommendation of ombudsman. Here a system of penalty for late or non compliance should be imposed to make the system more effective.
- Streamlining of process of ombudsman so as to reduce Turn around Time (TAT) for disposal of a complaint. The Registration and Referral model (Annexure A) of Financial Ombudsman Services-Australia is worth examining to reduce the average time for disposal of complaints. With the implementation of this system the average time to close a dispute was reduced from 95 days to 62 days by FOS-Australia.
- Most of the ombudsmen in their review given in Annual report of GBIC have raised concern about mis-selling. Though mis-selling has always been there in the insurance business but compared to 1998 the instances and reporting of mis-selling has increased. The pressure of competition among distribution channels, marketing of complex products like ULIPs and Health insurance has aggravated this issue. Hence, the five grounds on which complaints can be made to the ombudsman must be relooked. In this regard, efforts to bring distribution intermediaries (agents, brokers, bancassurance etc) and servicing intermediaries like (TPA, surveyors etc) within the ambit of ombudsman scheme must be made.

Conclusion

It must be appreciated that ombudsman scheme is doing well and is the corner stone of policyholder protection in India. The scheme which is a no cost scheme for the complainant encourages policyholders to come out and seek redressal from a neutral party without thinking of the cost. The spread of the scheme has also increased with 17 centres from 12 when it started as well as the support staff. This is all being done to resolve complaints in a cost effective, efficient and impartial manner as laid out in the objectives of RPG rules.

The scheme in its existing form has limitations in the present context and needs a relook and modifications as already explained. The modification with respect to maximum limit of dispute amount that can be entertained, structurally excluding certain segment of market (term insurance market), slow and outdated system and process for disposal of complaints and unscientific financing of the scheme can be looked into. It is said that justice delayed is justice denied. Though not completely applicable to this scheme yet improvements in servicing parameters like reduction in average time for disposal will go a long way in enhancing the image of ombudsman.

Table O1: Staffing Position of Insurance Ombudsman as on 01.04.2017 (Source http://www.gbic.co.in/StaffDirectory.html)

Ombudsman Centre	IRDAI	LIC	NIA	NIC	OIC	Professional Expert on Contract (Life)	Professional Expert on Contract (Non Life)	UIIC	Grand Total
GBIC		9			1				10
AHMEDABAD		5				2	2		9
BENGALURU		3				2	2		7
BHOPAL		4		1		1	1		7
BHUBANESWAR		3				2	2		7
CHANDIGARH		3				2	2		7
CHENNAI	1	4			1	1	1		8
DELHI		5	1			2	2	1	11
GUWAHATI		1				2	1		4
HYDERABAD		3		2		1	1		7
JAIPUR		3			1	1			5
KOCHI		3					2		5
KOLKATA		3		2	1	2	2		10
LUCKNOW		4		1		2	1		8
MUMBAI		3	3			2	2		10
NOIDA		2				1	2	1	6
PATNA		2			1				3
PUNE		3			1	1	1		6
Grand Total	1	63	4	6	6	24	24	2	130

T-1 : Trend of Disposal of Complaints Received (Source L1G1 of Relevant FY)

Parameter	2012-13	2013-14	2014-15	2015-16
Outstanding at the Beginning of the year	7176	8601	9617	6782
Received during the year	24782	26315	21484	26177
Disposed during the year	23357	25299	24319	30266
Outstanding at the end of the year	8601	9617	6782	2693
Disposal Ratio = Disposed/Received	0.94	0.96	1.13	1.16

T-2: Average Number of Days for Disposal of Complaints (Data from L1G1 of Respective Year)

Complaints / Year	2012-13	2013-14	2014-15	2015-16	*Estimated No of days in time band
Complaints disposed (Within 3 months)	17276	17423	4719	20703	45
Complaints disposed (3 months to 1 year)	4463	4808	11379	6649	225
Complaints disposed (Above 1 year)	1618	3068	8221	2914	450
Average No. Of days to dispose complaints	107	128	266	124	

T-2A: Average Number of Days O/S Complaints Still Pending as on Last Date of FY (Data from L1G1 of Respective Year)

Complaints / Year	2012-13	2013-14	2014-15	2015-16	*Estimated No of days in time band
Complaints outstanding (Within 3 months)	2311	2124	1977	1448	45
Complaints outstanding (3 months to 1 year)	3968	4127	3408	1223	225
Complaints outstanding (Above 1 year)	2322	3366	1397	22	450
Average No. Of days complaints is pending and O/S	237	264	219	130	

Estimated number of days for a time band is taken is the midpoint of the time band (example for the time band "within 3 months", the midpoint of time band is taken (3 months / 2 = 1.5 month) 30 days in a month is taken so the number of days comes to 1.5*30 = 45. The midpoint of "Above 1 year" is assumed to be between 12 months and 18 months i.e. 15 months. The average number of days for disposal/ Outstanding is calculated as weighted average with the no of complaints as the weight for the estimated number of days of a time band (for example for year 2012-13, 17276 is weight of 45 days) [SUMPRODUCT (No. of complaints of each band of a year, No. Of days in time band) / SUM(No of complaints for the year)].

Applying same calculation and data of Table T-2 with the following assumptions that non-entertainable complaints can be disposed in 15 days (on an average) as it does not require much lengthy processing. Thus, in the 1st band "Disposed (within 3 months)" the complaints of Table T-2 are reduced by number of non entertainable complaints of the respective year available in statement L7G7 of the respective year. The estimated number of days in the 1st time bands is also reduced by 15 i.e. it becomes 30. (@ Only in year 2014-15 the reduction spills over to 2nd band as there are lesser complaints which were disposed within 3 months than the non-entertainable for the year. So adjustment is made in 2nd band after fully adjusting in 1st band).

> It must be appreciated that ombudsman scheme is doing well and is the corner stone of policyholder protection in India. The scheme which is a no cost scheme for the complainant encourages policyholders to come out and seek redressal from a neutral party without thinking of the cost.

T-3: Average Number of Days for Disposal of Entertainable Complaints

Entertainable Complaints / Year	2012-13	2013-14	2014-15@	2015-16	Estimated No of days in time band
Disposed (Within 3 months)**	980	1234	0	5703	30
Disposed (3 months to 1 year)	4463	4808	3092	6649	225
Disposed (Above 1 year)	1618	3068	8221	2914	450
Average No. Of days to dispose	249	274	389	195	

T-4: Trend of Nature Wise Complaints Received

(Source L7G7 Statements of Annual Reports of GBIC)

Year / Percentage of Complaints	NOT ENTERTAINABLE (%age to Total complaints received)						ENTERTAINABLE (%age to Total complaints received)					
	BEYOND THE SCOPE OF RULE	NOT WITHIN JURISDICTION	NOT AVAILED OF INSURANCE COMPANY GRIEVANCE REDRESSAL MECHANISM	SUBJUDICE IN COURTS / FORUMS	TIME BARRED	TOTAL	PARTIAL OR TOTAL REPUDIATION	DISPUTE IN REGARDS TO PREMIUM PAYABLE PAID OR PAYABLE IN TERMS OFPOLICY	DISPUTE ON THE LEGAL CONSTRUCTION OF THE POLICIES IN SO FAR AS SUCH DISPUTE RELATES TO CLAIM	DELAY IN SETTLEMENT OF CLAIM	NON-ISSUE OF INSURANCE DOCUMENT TO CUSTOMER AFTER RECEIPT OF PREMIUM	TOTAL
2012-13	19	4	41	0	1	65	20	9	1	3	1	35
2013-14	21	4	34	1	2	62	19	16	0	3	0	38
2014-15	25	6	27	0	2	61	22	15	1	2	0	39
2015-16	19	9	27	1	1	57	24	16	1	1	0	43

T-4A: Trend of Nature Wise Complaints Received in Life Insurance

(Source L8 Statements of Annual Reports of GBIC)

Year	NOT ENTERTAINABLE (% to total received)						ENTERTAINABLE (% to total received)						
	BEYOND THE SCOPE OF RULE	NOT WITHIN JURISDICTION	NOT AVAILED OF INSURANCE COMPANY GRIEVANCE REDRESSAL MECHANISM	SUBJUDICE IN COURTS / FORUMS	TIME BARRED	TOTAL	PARTIAL OR TOTAL REPUDIATION	DISPUTE IN REGARDS TO PREMIUM PAYABLE PAID OR PAYABLE IN TERMS OFPOLICY	DISPUTE ON THE LEGAL CONSTRUCTION OF THE POLICIES IN SO FAR AS SUCH DISPUTE RELATES TO CLAIM	DELAY IN SETTLEMENT OF CLAIM	NON-ISSUE OF INSURANCE DOCUMENT TO CUSTOMER AFTER RECEIPT OF PREMIUM	TOTAL	TOTAL
2012-13	23	4	45	0	1	72	8	14	2	3	1	28	100
2013-14	25	4	35	1	2	66	8	23	1	2	0	34	100
2014-15	28	7	27	0	2	64	10	22	1	2	0	36	100
2015-16	20	10	27	1	2	60	15	23	1	1	0	40	100

T-4B: Trend of Nature Wise Complaints Received in Non-Life Insurance

(Source G8 Statements of Annual Reports of GBIC)

Year	NOT ENTERTAINABLE (% to total received)						ENTERTAINABLE (% to total received)						
	BEYOND THE SCOPE OF RULE	NOT WITHIN JURISDICTION	NOT AVAILED OF INSURANCE COMPANY GRIEVANCE REDRESSAL MECHANISM	SUBJUDICE IN COURTS / FORUMS	TIME BARRED	TOTAL	PARTIAL OR TOTAL REPUDIATION	DISPUTE IN REGARDS TO PREMIUM PAYABLE PAID OR PAYABLE IN TERMS OFPOLICY	DISPUTE ON THE LEGAL CONSTRUCTION OF THE POLICIES IN SO FAR AS SUCH DISPUTE RELATES TO CLAIM	DELAY IN SETTLEMENT OF CLAIM	NON-ISSUE OF INSURANCE DOCUMENT TO CUSTOMER AFTER RECEIPT OF PREMIUM	TOTAL	TOTAL
2012-13	14	3	34	0	1	53	41	1	0	5	1	47	100
2013-14	15	3	33	1	1	52	43	1	0	4	0	48	100
2014-15	18	5	28	0	2	53	45	1	0	1	0	47	100
2015-16	17	7	27	1	1	52	42	4	0	1	0	48	100

T-5: Costing of Ombudsman Scheme

(Source L1G1 Statement and Income & Expenditure Accounts in AR of GBIC)

Year	Complaints disposed		Consolidated Expenses of GBIC		Cost per complaint Disposed	
	No of Complaints Disposed	%age change over previous year	Amount in ₹ (Crs.)	%age change over previous year	Amount in ₹	%age change over previous year
2012-13	23357	NA	14.67	NA	6283	NA
2013-14	25299	8	16.34	11	6460	3
2014-15	24319	-4	19.24	18	7912	22
2015-16	30266	24	32.58	69	10766	36
%age Change in four years	30		122		71	

T-6: Percentage of Complaints Against Insurers Vis A Vis Percentage of Expense of Ombudsman Scheme Borne

Insurer	Life / Non Life	Period April 2012 to March 2016 (4 Years Total)				
		Complaints		Gross Premium Income		Share of complaints to share of Resources towards Ombudsman scheme
		No.	% to Total	Amt in ₹ (Crs.)	% to Total	
(A)	(B)	(C)	(D) = (C/ ΣC)*100	(E)	(F) = (E/ ΣE)*100	(G) = (D) / (E)
AEGON RELIGARE LIFE INS. CO. LTD.	Life	2222	2.25	1944.30	0.12	18.91
AVIVA LIFE	Life	1663	1.68	7308.17	0.45	3.77
BAJAJ-ALLIANZ LIFE	Life	2930	2.97	24650.45	1.51	1.97
BHARATI AXA LIFE	Life	1975	2.00	3878.83	0.24	8.43

Insurer	Life / Non Life	Period April 2012 to March 2016 (4 Years Total)				
		Complaints		Gross Premium Income		Share of complaints to share of Resources towards Ombudsman scheme
		No.	% to Total	Amt in ₹ (Crs.)	% to Total	
(A)	(B)	(C)	(D) = (C/ ΣC)*100	(E)	(F) = (E/ ΣE)*100	(G) = (D) / (E)
BIRLA SUN LIFE	Life	4958	5.02	20862.29	1.28	3.93
CANARA HSBC ORIENTAL BANK LIFE	Life	173	0.18	7452.54	0.46	0.38
DLF PARAMERICA LIFE INS. CO LTD	Life	711	0.72	2197.96	0.13	5.35
EDELWEISS TOKIOLICCO	Life	75	0.08	668.89	0.04	1.86
FUTURE GENERALI	Life	1194	1.21	2509.19	0.15	7.87
HDFC STANDARD LIFE	Life	9009	9.12	54528.45	3.34	2.73
ICICI-PRUDENTIAL	Life	4322	4.38	60437.90	3.70	1.18
IDBI FEDERAL LIFE INS. CO. LTD.	Life	421	0.43	3940.22	0.24	1.77
INDIAFIRST INSURANCE CO.	Life	213	0.22	7834.95	0.48	0.45
ING-VYSYA*/EXIDE LIFE INS	Life	1382	1.40	7647.50	0.47	2.99
KOTAK MAHINDRA-OM	Life	2284	2.31	12488.31	0.76	3.03
LIC OF INDIA	Life	15495	15.69	951857.74	58.25	0.27
MAX LIFE INSURANCE	Life	2135	2.16	31305.03	1.92	1.13
PNB MET-LIFE	Life	1530	1.55	9959.12	0.61	2.54
RELIANCE LIFE	Life	6213	6.29	17348.00	1.06	5.93
SAHARA INDIA LIFE	Life	16	0.02	733.93	0.04	0.36
SBI LIFE	Life	3507	3.55	49881.11	3.05	1.16
SHRIRAM LIFE	Life	519	0.53	2969.08	0.18	2.89
STAR UNION DAI-ICHI LIFE INS.CO.	Life	216	0.22	4459.70	0.27	0.80
TATA AIA LIFE	Life	1656	1.68	9685.75	0.59	2.83
AGRICULTURE INS. CO.	NL	83	0.08	12953.33	0.79	0.11
APOLLO MUNICH	NL	922	0.93	3137.76	0.19	4.86
BAJAJ ALLIANZ GENERAL	NL	895	0.91	19579.83	1.20	0.76
BHARATI AXA GENERAL	NL	427	0.43	5373.05	0.33	1.32
CHOLAMANDALAM	NL	277	0.28	7818.43	0.48	0.59
CIGNA TTK HEALTH INSURANCE	NL	15	0.02	165.97	0.01	1.50

Insurer	Life / Non Life	Period April 2012 to March 2016 (4 Years Total)				
		Complaints		Gross Premium Income		Share of complaints to share of Resources towards Ombudsman scheme
		No.	% to Total	Amt in ₹ (Crs.)	% to Total	
(A)	(B)	(C)	(D) = (C/ ΣC)*100	(E)	(F) = (E/ ΣE)*100	(G) = (D) / (E)
ECGC	NL	9	0.01	5144.09	0.31	0.03
FUTURE GENERALI GEN.	NL	187	0.19	5361.44	0.33	0.58
HDFC ERGO GEN	NL	602	0.61	11921.93	0.73	0.84
ICICI LOMBARD	NL	1739	1.76	27758.65	1.70	1.04
IFFCO TOKIO	NL	408	0.41	12517.24	0.77	0.54
L&T GENERAL	NL	75	0.08	1240.95	0.08	1.00
LIBERTY VIDEOCON	NL	33	0.03	824.57	0.05	0.66
MAGMA HD	NL	40	0.04	1397.60	0.09	0.47
MAX BUPA	NL	843	0.85	1364.73	0.08	10.22
RAHEJA QBE GENERAL	NL	14	0.01	94.91	0.01	2.44
RELIANCE GENERAL	NL	1142	1.16	9906.22	0.61	1.91
RELIGARE HEALTH INSURANCE	NL	251	0.25	970.21	0.06	4.28
ROYAL SUNDARAM	NL	519	0.53	6260.36	0.38	1.37
SBI GENERAL	NL	224	0.23	5575.17	0.34	0.66
SHRIRAM GEN INS.	NL	266	0.27	6260.75	0.38	0.70
STAR HEALTH & ALLIED INS	NL	2409	2.44	5427.81	0.33	7.34
TATA AIG GENERAL	NL	762	0.77	10170.48	0.62	1.24
THE NATIONAL	NL	4569	4.63	42757.17	2.62	1.77
THE NEW INDIA	NL	6673	6.76	58844.75	3.60	1.88
THE ORIENTAL	NL	4345	4.40	30193.70	1.85	2.38
THE UNITED INDIA	NL	5965	6.04	41917.06	2.57	2.35
UNIVERSAL SOMPO	NL	239	0.24	2679.68	0.16	1.48
Industry Total		98752	100.00	1634167.24	100.00	1.00
Total of Life Insurer		64819	65.64	1296549.40	79.34	0.83
Total of Non Life Insurer		33933	34.36	337617.84	20.66	1.66
Stand Alone Health Insurer (SAHI)		4440	4.50	11066.48	0.68	6.64
Specialised Insurers		92	0.09	18097.42	1.11	0.08

Six Complaints Against CHNHB Associates for which the Respective Data of Premium is not Available and it is not Member of GBIC is Excluded in Table T-6

Source of data and method of calculation in Table T-6: The Gross premium income and complaints data for four years is summed up in the Table -6.

Insurer / Parameter	Complaints		Gross Premium Income		Ratio of Share of complaints to share of Resources towards Ombudsman scheme
	No.	% to Total	Amt in ₹ (Crs.)	% to Total	
Life	L3 statements of Annual reports of GBIC	Calculated	Table -3 of IRDAI Annual statistics giving Total Premium Income	Calculated	Calculated
Non-Life	G3 statements of Annual reports of GBIC		Table 45 of IRDAI Annual Statistics giving Gross domestic premium income		

T-7: Movement of Complaints from Insurers to Ombudsman

(Source IRDAI Annual Statistics, Annual Report of GBIC)

Insurer	L / NL	Complaints resolved by Insurers during the period April '11 to March '15	Complainants dissatisfied with Insurer's Grievance Resolution and complaining to Ombudsman during April '12 to March '16	Complaints entertainable out of dissatisfied Complainants approaching ombudsman for the period April '12 to March '16	Percentage of complainants dissatisfied with the Grievance redressal of Insurer	Awards and Recommendation out of entertainable complaints	Percentage of dissatisfied complainants proven right by Ombudsman
(A)	(B)	(C)	(D)	(E)	F=D/C *100	G	H = G/D *100
AEGON RELIGARE LIFE INS. CO. LTD.	L	24133	1612	1149	6.68	699	43.36
AVIVA LIFE	L	33259	1131	639	3.40	406	35.90
BAJAJ-ALLIANZ LIFE	L	131316	1985	1000	1.51	543	27.36
BHARATI AXA LIFE	L	27368	1406	872	5.14	584	41.54
BIRLA SUN LIFE	L	96784	3363	2104	3.47	939	27.92
CANARA HSBC ORIENTAL BANK LIFE	L	19390	125	40	0.64	14	11.20
DLF PARAMERICA LIFE INS. CO LTD	L	3984	492	372	12.35	200	40.65
EDELWEISS TOKIOLICCO	L	779	43	23	5.52	7	16.28
FUTURE GENERALI	L	39932	829	542	2.08	277	33.41
HDFC STANDARD LIFE	L	168483	5861	3062	3.48	1715	29.26
ICICI-PRUDENTIAL	L	73214	2797	1371	3.82	652	23.31
IDBI FEDERAL LIFE INS. CO. LTD.	L	2960	312	178	10.54	58	18.59
INDIAFIRST INSURANCE CO.	L	4606	146	50	3.17	18	12.33
ING-VYSYA*/EXIDE LIFE INS	L	34555	978	552	2.83	272	27.81

Insurer	L / NL	Complaints resolved by Insurers during the period April '11 to March '15	Complainants dissatisfied with Insurer's Grievance Resolution and complaining to Ombudsman during April '12 to March '16	Complaints entertainable out of dissatisfied Complainants approaching ombudsman for the period April '12 to March '16	Percentage of complainants dissatisfied with the Grievance redressal of Insurer	Awards and Recommendation out of entertainable complaints	Percentage of dissatisfied complainants proven right by Ombudsman
(A)	(B)	(C)	(D)	(E)	F=D/C *100	G	H = G/D *100
KOTAK MAHINDRA-OM	L	28228	1537	914	5.44	460	29.93
LIC OF INDIA	L	291562	9960	3970	3.42	1810	18.17
MAX LIFE INSURANCE	L	62199	1394	642	2.24	327	23.46
MET-LIFE / PNB MET-LIFE	L	15947	1012	574	6.35	364	35.97
RELIANCE LIFE	L	127582	4095	2508	3.21	1157	28.25
SAHARA INDIA LIFE	L	109	16	2	14.68	0	0.00
SBI LIFE	L	65490	2244	987	3.43	500	22.28
SHRIRAM LIFE	L	890	378	178	42.47	93	24.60
STAR UNION DAI-ICHI LIFE INS.CO.	L	4241	141	46	3.32	18	12.77
TATA AIA LIFE	L	41117	1104	516	2.69	312	28.26
AGRICULTURE INS. CO.	NL	0	43	19	NA	3	6.98
APOLLO MUNICH	NL	6109	646	498	10.57	270	41.80
BAJAJ ALLIANZ GENERAL	NL	32900	625	388	1.90	220	35.20
BHARATI AXA GENERAL	NL	17510	281	172	1.60	93	33.10
CHOLAMANDALAM	NL	19730	190	107	0.96	68	35.79
CIGNA TTK HEALTH INSURANCE	NL	71	9	4	12.68	1	11.11
ECGC	NL	282	8	1	2.84	0	0.00
FUTURE GENERALI GEN.	NL	13523	129	81	0.95	45	34.88
HDFC ERGO GEN	NL	5865	425	246	7.25	125	29.41
ICICI LOMBARD	NL	50148	1187	657	2.37	324	27.30
IFFCO TOKIO	NL	12529	267	173	2.13	112	41.95
L&T GENERAL	NL	747	60	31	8.03	14	23.33
LIBERTY VIDEOCON	NL	438	27	12	6.16	6	22.22
MAGMA HD	NL	136	27	16	19.85	9	33.33
MAX BUPA	NL	2632	566	369	21.50	187	33.04
RAHEJA QBE GENERAL	NL	5	10	0	200.00	0	0.00
RELIANCE GENERAL	NL	21637	777	512	3.59	454	58.43
RELIGARE HEALTH INSURANCE	NL	1004	182	124	18.13	59	32.42
ROYAL SUNDARAM	NL	17092	362	218	2.12	128	35.36

Insurer	L / NL	Complaints resolved by Insurers during the period April '11 to March '15	Complainants dissatisfied with Insurer's Grievance Resolution and complaining to Ombudsman during April '12 to March '16	Complaints entertainable out of dissatisfied Complainants approaching ombudsman for the period April '12 to March '16	Percentage of complainants dissatisfied with the Grievance redressal of Insurer	Awards and Recommendation out of entertainable complaints	Percentage of dissatisfied complainants proven right by Ombudsman
(A)	(B)	(C)	(D)	(E)	F=D/C *100	G	H = G/D *100
SBI GENERAL	NL	2703	154	65	5.70	25	16.23
SHRIRAM GEN INS.	NL	770	173	107	22.47	69	39.88
STAR HEALTH & ALLIED INS	NL	3851	1651	1238	42.87	496	30.04
TATA AIG GENERAL	NL	18663	482	256	2.58	113	23.44
THE NATIONAL	NL	15657	3059	2066	19.54	1277	41.75
THE NEW INDIA	NL	11769	4756	3335	40.41	2050	43.10
THE ORIENTAL	NL	13949	3031	2196	21.73	1492	49.22
THE UNITED INDIA	NL	22698	4231	3140	18.64	2170	51.29
UNIVERSAL SOMPO	NL	1588	149	92	9.38	45	30.20
Total for the Industry		1592134	66468	38414	4.17	21280	32.02

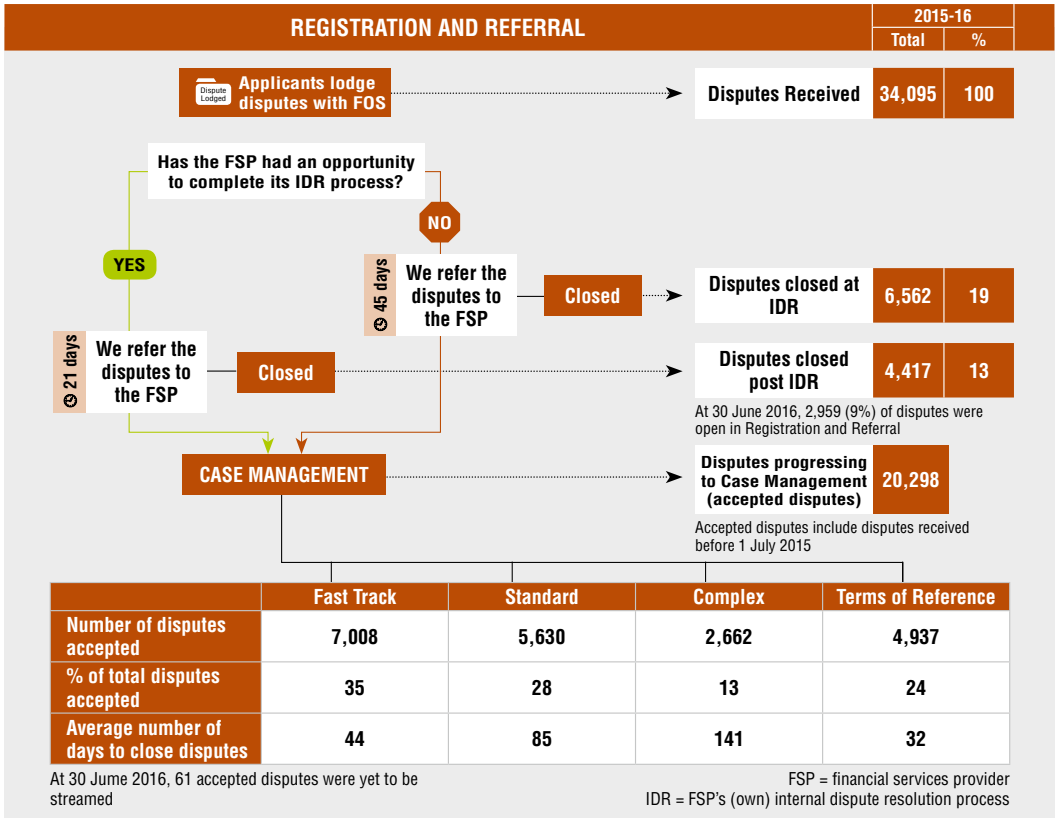
Data Source for Table T-7

Insurer / Parameter	Complaints resolved by Insurers during the period April '11 to March '15	Complainants dissatisfied with Insurer's Grievance Resolution and complaining to Ombudsman during April '12 to March '16	Complaints entertainable out of dissatisfied Complainants approaching ombudsman for the period April '12 to March '16	Percentage of complainants dissatisfied with the Grievance redressal of Insurer	Awards and Recommendation out of entertainable complaints	Percentage of dissatisfied complainants proven right by Ombudsman
Life	Table T-41 and T-42 of IRDAI annual statistics	Total complaints filed with ombudsman excluding those that did not avail Insurance company grievance redressal mechanism (Statement L9 for life insurer and G9 for non-life insurer of GBIC Annual report)	Total Entertainable complaints from (statement L9 for life insurer and G9 for non-life insurer of GBIC Annual report)	Calculated	From Awards and recommendation data in L3 for life insurers and G3 for Non-life insurers in GBIC Annual report	Calculated
Non-Life	Table T-83 and T-91 of IRDAI annual statistics					

"Annexure A"

The Registration and Referral Model of Dispute Resolution of Financial Ombudsman Service – Australia

(Source Annual Review of 2015-16 of FOS-Australia)



	Fast Track	Standard	Complex	Terms of Reference
Number of disputes accepted	7,008	5,630	2,662	4,937
% of total disputes accepted	35	28	13	24
Average number of days to close disputes	44	85	141	32

At 30 Jume 2016, 61 accepted disputes were yet to be streamed

FSP = financial services provider
IDR = FSP's (own) internal dispute resolution process

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Statement L1G1 of GBIC Annual Report 2015-16

Calculated from respective figures available at statement L1G1 of GBIC Annual Report 2015-16

Statement L4G4 of GBIC Annual Report 2015-16

Statement L7G7 of GBIC Annual Report 2015-16

Engagement notification dated 25.08.2015 issued by GBIC available in internet

http://www.networkfso.org/about-ombudsmen.html

http://www.networkfso.org/links.html

IRDAI Annual report 2015-16

INFO Network: Effective approaches to fundamental principle" available at http://www.networkfso.org/about-ombudsmen.html

Abbreviations Used:

IRDAI	Insurance Regulatory and Development Authority of India
EDR	External dispute resolution
GBIC	Governing Body of Insurance Council
LIC	Life Insurance Corporation of India
NIA	National Insurance Academy
NIC	National Insurance Company
OIC	Oriental Insurance Company
UIIC	United India Insurance Company
YoY	Year on Year
AR	Annual Report
EA	Effective Approaches
GOI	Government of India

Consolation Prize

Technical Paper Essay Competition (Life)

Digitalization – Implication for the Life Insurance Industry

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Abstract

'D' has become a buzz-word, now-a-days. De-monetisation, declared on 8th November, 2016, has been a trigger for going to *'Digital'* from *'Physical'*. At its crux, is the government of India's *'Digital India'* programme. Looking at the current internet-penetration in India, 'Digital India' can make it possible to encompass the Indian insurable population, for 'Going Digital', to have life assurance cover or life annuity security.

'Going Digital' essentially requires a paradigm shift for life assurance, which has always been perceived as a push-product with a human touch. In view of the age-old and quite popular saying, that, *"Life assurance is never purchased, and it always have to be sold",* its customers really have to be in purchaser-mode, rather than, its intermediaries being in seller-mode.

Millennial generation, which is, the population born between 1980 to 2000, and grown-up with internet through mobile devices; is an important customer-base, almost compelling the life insurers to 'Go Digital'.

Finding the new avenues for premium-growth through enriched customer-experience, favourable underwriting, and good governance; can be achieved with ubiquitous adoption of digital technologies.

Regulatory compliance can be easy, better, and faster with the digital innovation.

'Going Digital' may help the elimination of an intermediary and the related cost for having life assurance through the intermediaries, and thereby making it more affordable.

Keywords

- Digital
- Millennial Generation
- Insurance Density
- Insurance Penetration
- Insurance Reach
- Omni-Channel

Executive Summary

- 'Going Digital' is perceived differently by the different executives; however, its business-specific perception, understanding, and implementation will lead to the desired and desirable results.
- 'Going Digital' should aim at protecting the interests of all the stake-holders of life assurance business, with the top priority being given to its customers, followed by the intermediaries, and equally considering the administration or back-office.
- Shift from intermediaries' seller-mode to customers' purchaser-mode will necessitate the use of digital technologies to facilitate the customer in all the 3 stages: pre-purchase, purchase, and post-purchase, which will help the customer's decision, implementation, and realisation.
- Digital capabilities should aim at the friction-less administration or back-office processing of a life office, again, in all the 3 stages: sell, service, and settle.
- Optimal "Insurance-**Reach**" in the country, which appears to be a more sensible measure of success of insurance, rather than, the traditional measures, such as, 'insurance-penetration' and 'insurance-density', both of which, considers the insurance-premium, rather than, insurance-coverage.

Introduction: What is 'Digital'?

As cited in *Mckinsey Digital's 'raising your digital quotient' report,* 'digital' connotes broadly-varied and different perceptions for the different executives. Firstly, 'digital' is perceived to be about technology. Secondly, 'digital' is perceived to be about a new channel for customer-connect. Thirdly, 'digital' is perceived to be an entirely new way of doing the business, aiming at the minimum resources, maximum efficiency, and ultimate quality. Because of such diverse perceptions, reflecting a lack of alignment and common vision about the business-future, piece-meal initiatives or mis-guided efforts of the leadership teams are quite common; resulting into missed opportunities, sluggish performance, or false starts. Therefore, it is essential to clearly understand the meaning and interpretation of 'digital' from the point-of-view of that particular business.

'Digital' as an entirely new way of doing the business, connotes 3 attributes:

1. Creating value at the new frontiers of the business-world.
2. Focus on cycle of core processes, executing a vision around customer-experiences.
3. Foundational capabilities, supporting the entire structure.

'Going Digital' requires an honest introspection for the re-examination of the entire way of doing business and understanding, searching for the new frontiers of value, which may be either developing entirely new businesses or identifying and pursuing new value-pools in existing sectors.

'Going Digital' for Customer

Pre-Purchase:

'Going Digital' plays an important role in advertising and publicity of the life assurance product, which can be easily personalized, when used through social media, such as, facebook. Important events in the life of a person, such as, birth-day, job-promotion, marriage and its anniversary, child-birth, retirement, etc., can be best utilized for the personalized guidance, using the digital capabilities.

Purchase:

'Going Digital' should also aim at facilitating the customer to arrive at the purchase-decision, which can be attained through the information, provided easily, accurately, and reliably. It is obviously important to know the behavioural pattern and expectations of today's customers, who wish to use their wish about what, when, where of their wished product, and that too at the 'best' price. The basic or hassle-free plans of life assurance shall be made available for on-line purchase, providing for the 'rebate' in the premium, which can be a great motivator for the purchaser-customer of life assurance. End-to-end underwriting and acceptance of the proposal is feasible, using the digital methodologies. Delivering the 'right' product to the customer is possible, when a focus is ensured for flexibility, efficiency, and speed. An accurate 'comparison' of the available products will certainly facilitate the decision-making of the customer. 'Going Digital' also helps for the marketing-decisions of the insurer when the data and metrics about the customer in-sights are effectively used. Need-based analysis of the customer can be conveniently done

and tailor-made products or product-combinations can be effectively done, using the digital methodologies; and possibly, the customer will be more open while sharing the personal and financial data, when, ensured about 'no human intervention'. With the on-line purchase of a life assurance policy, such an empowered customer can have 'low cost, more convenience', 'low premium, more protection'.

Post-Purchase:

Continuation of life assurance policies is equally important, and necessitates the punctual payment(s) of renewal premium(s). Intimation of the premium-due through mobile device with the readily available 'link' or 'app' for the premium-payment, providing for a certain discount, will be the convenient and economical mode, and also the most-motivating for the customer.

The basic service-requirements, such as, premium-paid certificate, revival quotation, policy-loan quotation, surrender quotation, other policy-related enquiries, etc., Can and are being made available through the 'portal', which is the best application of digital methodologies, indicating the total customer-centricity.

'Going Digital' for Back-Office Administration

'Going Digital' will substantially reduce the foot-fall in the office, and thereby the related costs.

Sell:

Automation of the processes, such as, 'underwriting', issue of electronic policy, can improve the task-effectiveness and cost-efficiency. The much-talked concept of e-K.Y.C. or common K.Y.C. is feasible only through 'Going Digital'.

Service:

On-line receipt of service-requests from the customers and fulfilling their requirements, ultimately leads to the speed, security, and satisfaction.

Settle:

Because of the unique characteristic of a life assurance product, that is, 'sacrifice instant and benefit distant'; the 'moment of truth' for any customer of life assurance, can only be perceived at the time of 'settlement-of-claim'. 'Going Digital' for this ultimate and important process, facilitates the easy claimant-identification, and speedy and safe claim-payment through bank-account.

Analysis:

Percentage share of various channels of distribution in terms of number of policies-issued and amount of premium, of life assurance, during the financial year: 2015-2016, is shown below:

Share of Various Channels of Distribution - Number of Policies-Issued and Amount of Premium - Financial Year: 2015-2016.

Channel	Individual Business		Group Business		Total Business	
	Policies	Gross Premium	Policies	Gross Premium	Policies	Gross Premium
Brokers	4.00%	4.00%	7.00%	39.00%	4.00%	24.00%
Corporate agent – banks	13.00%	11.00%	44.00%	4.00%	14.00%	7.00%
Corporate agent - other than banks	3.00%	5.00%	11.00%	1.00%	3.00%	2.00%
Direct sale - on-line	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Direct sale - other than on-line	10.00%	8.00%	3.00%	43.00%	9.00%	28.00%
Individual agents	69.00%	70.00%	33.00%	6.00%	68.00%	33.00%
Micro insurance agents	0.02%	0.00%	0.04%	0.00%	0.02%	0.00%
Web-aggregators	0.21%	0.23%	0.00%	0.00%	0.20%	0.10%
Others	0.01%	0.15%	0.03%	4.78%	0.01%	2.82%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Source: I.R.D.A.I. Annual Report - 2015-2016.

It is evident from the table, that, on-line sale is just 2% of the total life assurance business; and the potential is quite evident, because of the various reasons, such as, increasing awareness about life assurance among the people, increasing number of inter-net consumers, and government of India's 'Digital India' programme, etc.

Following is an extract from a report, ***'The Future of Inter-Net Report'***, which speaks essential and enough about India and inter-net.

The Future of Inter-Net Report – Projections for 2020:

- 730 Million (73 crores) inter-net users in India.
- 75% of new inter-net user-growth from rural areas.
- 70% of e-commerce transactions via mobile-phones.
- 75% of new inter-net users to consume the data in local languages.
- India to remain the fastest-growing inter-net market.

As mentioned in the 11th annual report of inter-net and mobile association of India (I.A.M.A.I.), For the financial year: 2014-2015, *"with 1.25 Billion (125 crores) population and 900-million (90 crores), that is, 72% strong mobile subscriber base, India holds huge potential for machine-to-machine (M2M) solutions, and with propagation of internet-of-things (I-O-T). The tech companies are immersing in M2M computing, which is making our smart world a lot smarter. The sector has a multi-dimensional growth at present, and comes across several policy and regulatory challenges."*

Regulator's e-Initiative for Proposal-Form, Policy-Document and Policy-Account

Leading to the over-all benefit of customer, insurer, and intermediary; insurance regulatory and development authority of India (I.R.D.A.I.), In its (issuance of e-insurance policies) regulations, dated 13th June, 2016, effective from 1st October, 2016, with first amendment on 2nd December, 2016, have made it mandatory for the insurers, for issuance in an electronic form, digitally-signed policy-document, known as, "e-insurance policy" or "electronic insurance policy", as an evidence of insurance contract; either directly to the policy-holder, or through the platform of registered insurance repository, and therefore, submission of electronic proposal-form, for the policies fulfilling a defined criteria in terms of sum-insured or premium (single or annual); and without any such criteria, in disaster-prone and vulnerable areas.

The above chart indicates that there will be a good majority of electronic insurance policies.

This will lead to a huge reduction in cost in terms of policy-document-stationery, policy-document-printing, policy-document-despatch, and all related administrative labour and cost.

Also, these electronic insurance policies will ensure the complete avoidance of "loss" and "mis-use" of policy-document.

Electronic insurance policies will facilitate, in a big way, its issuance, servicing and claim-settlement, ensuring the optimal speed and accuracy, leading to the maximum satisfaction for the customer with the minimum administration for the insurer and intermediary.

Every insurer, soliciting insurance business through electronic mode, shall create an **e-proposal-form**, similar to the physical proposal-form, approved by the authority. Such form should enable capture of information in electronic form, that would enable easy processing and servicing.

A person can open an electronic account, known as, **"e-insurance account"** or **"eIA"**, with an insurance repository, where-in, the portfolios of insurance policies of a policy-holder are held in an electronic form.

Also, in case of the existing policies, policy-holders, who wish to avail the facility of electronic insurance policy, may register their choice with the insurer.

Criteria, in Terms of Either Sum-Insured or Premium (Single or Annual), for Issuance of e-Insurance Policy.

Line of Business	Sum-Insured (Equal to or Exceeding) (Rupees)	Premium (Single or Annual) (Equal to or Exceeding) (Rupees)
Pure term assurance (excluding term assurance with return-of-premium {excluding micro insurance})	☐ 10,00,000	☐ 10,000
Other than pure term assurance (including term assurance with return-of-premium {excluding micro insurance})	☐ 1,00,000	☐ 10,000
Pension policies	Not Applicable	☐ 10,000
Immediate annuities (pension per annum)	Not Applicable	☐ 10,000
All retail general insurance policies (except motor insurance)	☐ 10,00,000	☐ 5,000
Individual health insurance	☐ 5,00,000	☐ 10,000
Motor retail insurance	All Policies	All Policies
Miscellaneous: individual personal accident insurance and domestic travel insurance	☐ 10,00,000	☐ 5,000
Miscellaneous: individual over-seas travel insurance	All Policies	All Policies

This data-base of "e-insurance account" or "eIA" can be utilized very effectively to analyse the adequacy of insurance-protection for the person.

Moreover, this will also help to know the insured proportion of the insurable population, if linked and matched with the 'Aadhaar' data-base.

Life Assurance-Identification Number (L.A.I.N.) can be created for each individual, which will have the details of all the life assurance policies on the life of that particular individual. This will help to know the "Gap", if any, between the insurability and actual coverage for life assurance. Also, this will help the underwriter for the financial underwriting, which means, total life assurance cover should not exceed the total human life value of that particular individual. Common K.Y.C. Can be easily applied for all life assurance policies, in one instance. Also, common servicing matters, such as, change in address, can be easily done for all the policies, together.

An insurer may offer **discount** (in accordance with the discount-rates, filed under the product approval or the 'file & use' guide-lines or as specified by the authority) in the premium-rates to the policy-holders for such electronic insurance policies, exempt from issuance in physical form.

Conclusions:

'Going Digital' as a new way of doing the life assurance business, aiming at the continuous improvement in effectiveness and efficiency, is a 'call of the day'. Ensuring the enriched satisfaction of the existing customers, and more importantly, the optimum encompassment of the insurable population can be easily achieved by 'Going Digital'.

According to Mr. Harshveer Singh, leader of Bain's life insurance sector in Asia-pacific, *"today's innovations will be tomorrow's standard practices, so there is little tim.*

Merit Winner

Technical Paper Essay Competition (General)

Cyber Risk Insurance – Issues and Challenges

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Part 1

(The Cyber Risk Landscape and Cyber-Insurance)

"It is estimated that approximately 80% of cyber-attacks can be prevented or mitigated by basic information risk management"

– The UK Gov Communications Headquarters (GCHQ)

Abstract

Over the past decade our dependence on network systems and digital information has increased extraordinarily. However, the cyberspace, in which the economic and informational interaction takes place, is also vulnerable to many forms of risks and attacks. 'Cyber risks' thus continue to be a potential area of concern and pose challenge for the insurance aspect. To develop insurance products that cover cyber risks, the insurance community will have to make fundamental changes in their approach and build complementary knowledge and legal systems and institutions for proper insurability. I also discuss the reasons that have resulted in huge protection gap in this area concerning the issue and challenges thrown open by cyber risks.

cyber risk insurance as a solution to the new found risks, suffers from traditional problems of moral hazard and informational asymmetries, which could only be overcome with transparency of reporting structure to a notified agency. It would be important to see how insurers wish to close the huge protection gap as investments in cyber infrastructures continue to grow enormously. In these times of heavy competition in conventional insurance products and negative interest rate environment, cyber risk presents a major opportunity for the insurance industry for growth.

For developing robust foundation for cyber risk insurance, insurers will have to promote and foster cyber security measures and need to draw attention, particularly of the public and private sector, with awareness and measures of cyber-hygiene as incentives to continued insurability. Similarly, firms would also need to follow best practices in face of the dynamic nature of cyber risks. It is expected that insurers could lead by example in the area of adherence to cyber security as they too have huge data assets to protect.

Keywords

Cyber risk, Insurability, Information Security, Data Protection.

Introduction

Whereas the 'internet' stands for a global computer network providing a variety of information and communication facilities, the 'cyberspace' is the notional environment in which communication over computer networks occurs. The 'World Wide Web', or simply the 'Web' or 'www' is a way of accessing information over the medium of the Internet. The www, an information-sharing model that is built on top of the Internet is further driven by the specification of sharing of information across the network and is guided by an Internet Protocol (IP). Today, with over 1 billion websites and 6.4 Billion 'things' connected on the internet[1], the cyberspace has truly become a ubiquitous dimension in itself and a host for all kinds of information services and economic activities.

During the last decade the shift from physical space to cyberspace has been so phenomenal that we experienced a bursting of bubble on the financial markets. In the year 2000, the dot-com bubble, had been caused by irrational exuberance regarding the valuations of the internet businesses by the markets. However, the cyberspace has come a long way and continues to grow in size and significance. In wake of its importance and rate of penetration, the incumbent businesses, governments and other entities have adapted to the internet mode of delivery of services and as such there is exponential growth in opportunities coupled with exposure to new kinds of vulnerabilities known as cyber-risks.

The Hegemony of Cyberspace

The age of information technology in which we live has propelled the world to a new dimension which the thinkers call the fourth industrial revolution that is characterized by a fusion of technologies, blurring the lines between the physical, digital, and biological spheres. The cyber space has already gained hegemony over the physical space and today they have almost full dominion on information flows, dissemination, provision of financial services and aspects of transactive, commercial and routine nature[2].

I therefore intent to discuss the issues and challenges of this phenomenon from the insurer's aspect so that cyber insurance products that secure cyber assets and investments in cyber infrastructures could be devised properly against the vulnerabilities it faces, help to secure business interruption losses arising out of cyber attacks and foster a robust cyber security environment for continued insurability purpose, thus our discussion is centered around the following concerns:

- **Huge protection gap for cyber infrastructures**

  The growth and investments in internet network assets have not commensurate with insurance coverage they deserve; as a result, there is huge coverage gap in this space. This is because the cyber risks are thought to be too big to insure, similarly they are also complex and interrelated so as to assess their impact for insurance.

- **Presence of asymmetric information and moral hazard in cyber insurance**

  Like the other forms of insurance the cyber-insurance space suffers from presence of *asymmetric information* and *moral hazard* problem making it difficult to provide comprehensive solution. This aspect coupled with lack of historic information with regard to cyber incidences and attacks, the kind of data that had been compromised and its ramification makes it difficult to devise products. Similarly, there is very limited availability of data on claims if such liabilities were covered and the average claims pay-out per event by the insurer. All such aspects make it difficult to tailor cyber risk products.

- **Increasing dependence on networks and systems calls for protection**

  In the 21st century, the cyberspace has become a social-good of utmost importance and deserves protection and resilience from loss of assets because of increasing reliance on the systems, as a result, the cyberspace has become both an indispensable asset and liability.

- **The traditional insurance model for new found risks is not adequate**

  The traditional methodology for covering of risks may not work for the cyber risks as the nature of these risks are quite different; these risks have potential to propel multiplicity in claims. Traditional liability policies offer protection to physical components but do not cover the loss of intangibles such as data, interruption losses and legal liabilities arising out of the same, therefore, a new outlook would be required to offer solution to such risks.

> The growth and investments in internet network assets have not commensurate with insurance coverage they deserve; as a result, there is huge coverage gap in this space. This is because the cyber risks are thought to be too big to insure, similarly they are also complex and interrelated so as to assess their impact for insurance.

The Ubiquity of Network Systems and Digital Information

With rising digital assets, infrastructures and multiplicity of technology platforms, there is also rise in incidences such as hacking and spamming of networks and websites with malicious intent. What we observe in the interconnected world is more and more critical information is getting digitized, dematerialized and being stored on to servers. Similarly, services are becoming cheap and demonetized in the online world thereby increasing our dependence on network systems and digital information, all such factors are but accentuating the risks.

Whereas the benefits accruing from the internet business and service model are immense, as they help the economy to function optimally and efficiently through speedy services, the data of customers and citizens also gets exposed to certain vulnerabilities. In the past couple of years there have been high profile attacks on the systems of reputed commercial organizations having caused loss of brand equity and harm to reputation of the brand/ organization including multiple law suits from aggrieved parties.

Today, the internet has become the absolute tool for all sorts of organizations, governments and businesses to reach out to people in a cost effective manner. The internet technologies have permeated social, economic, health, financial and political systems so much so that there is no turning back from this point. With the power of the internet and digital technology and growth of complementary assets, businesses are finding it unusually easy to establish identity, on-boarding and providing seamless service experience through the internet (we discuss the India specific *'IndiaStack'* in further sections).

Institutions now simply have to leverage on the computing power and maintain electronic folios or customer ids which form the basis for recordings of all transactive information also making their retrieval easy for further treatment. Thus computers and networks that connect them have become an integral part of our lives. It is therefore pertinent that such organizations would actively seek to secure their cyber presence and digital assets through cyber risk insurance.

The Exponential Rise in Electronic Network Based Clearing

There is increasing adoption of technology in all of the sectors especially banking, insurance and e-commerce in India. As per the latest RBI Annual Report, the share of electronic transactions in total transactions in volume terms has moved up to 84.4 per cent from 74.6 per cent in the previous year. Likewise in value terms, their share has also inched up to 95.2 per cent from 94.6 per cent. At end-March 2016, the national electronic funds transfer (NEFT) facility was available through 130,013 branches of 172 banks, in addition to business correspondent (BC) outlets. NEFT handled 1.2 billion transactions valued at around ₹ 83 trillion (approximately $1.3 tn) up from 928 million transactions for ₹ 60 trillion (approximately $ 0.9 tn) in the previous year. In March 2016, NEFT processed the highest ever monthly volume of 129 million transactions[3].

There have been attempts for raising awareness about cyber-risks by the agencies of government and sector specific regulators by issuance of guidelines. Organizations with cyber presence not only hold proprietary,

customer information and data regarding their business but also share the same with various third-parties. Information leakages from firms through cyber crime may be used for financial gain through extortion, identity theft, misappropriation of intellectual property, or other criminal activities. Malicious cyber attacks against an organizations critical system may cause interruption for an unpredictable period. Hence, it is important that apart from cyber defense mechanism through security measures, firms would additionally seek cyber risk insurance as a solution to business interruptions.

Cyber Risks - Risk Transfer & Mitigation

The use of internet technology by all kind of institutions has gained further momentum in the wake of falling prices of technological equipments, rising mobility, open knowledge and transfer of source code and more importantly the imperative of competition for organizations to go digital and standout. With this aspect the frequency and impact of cyber attacks have also increased manifold. The most important cost of cyber crime, however, comes in the form of reputation damage and the loss of hard earned brand equity. Among other things an incidence of data breach or intrusion damages its revenue streams, erodes competitiveness in the marketplace, and disturbs the level of its standing while also posing uncertainty to business continuity.

How do firms deal with cyber risks (see Exhibit-I for categories) and how do they do risk mitigation is of interest. In India, cyber-insurance is still in nascent stage, few insurers are providing policies regarding the new form of risks posed by the connected and borderless cyber world. Large firms intending to go for cyber-risk insurance generally place their requirement through a Request for Proposal[4] (RFP), small firms typically go for self insurance. The Information Technology Act (2000) gave a further fillip to conducting of transactions in a computerized environment by providing a legal underpinning. The internet penetration has gradually increased leading to increasing use of the medium as a channel for delivery of financial and consumer products and services. This has also brought in many small and medium size enterprises with portals to the fore, which lack good security measures or insurance solution.

Nature of Cyber Risks and Insurability Challenge

The types of losses arising from breach of cyber security are very complex and interconnected. The loss assessment process is critical and intricate, the data and information regarding such breaches are not disclosed with transparency because of fear of loss of brand equity. The security measures that the insured has put in place will surely influence the decision of the insurer regarding the offer of cover. Similarly, cyber risk insurance cannot be 'one size fits all', insurers will have to deal on case to case basis and form a broad consensus regarding grouping of prospects in to broad market segments for underwriting aspect.

Cyber risk insurance can play fundamental role in developing the digital economy. It is often assumed that the issues of cyber security and cyber insurance are separate – that cyber insurance is no substitute for proper cyber security – but in truth the two are intertwined. The questions insurers ask the prospective and the policy terms may be more effective than exhortation or regulation in making the firm's directors think carefully about the risks facing the business. Insurers have a vested interest in providing expert advice to policyholders and have a long history of improving practice in various areas from establishing modern fire brigades to workplace safety[5].

Quantification Issues for Cyber Risks

Estimating the financial costs in case of cyber attacks are difficult as there are opportunity costs in terms of time and resources when such attacks materialize. The first step in putting a dollar figure[6] on cyber risks is to identify the prospect's most important assets and its greatest vulnerabilities. Cyber risks generally fall into two categories:

1) Those involving services shutting down, and
2) Those that compromise information, ranging from sensitive data, to corporate secrets, to bank accounts.

The challenge then is to build a smart, well-designed, cyber risk model (see Exhibit-II) that is able to analyze potential direct revenue, liability, and brand loss scenarios and must quantify how much their future revenues of the firm will fall if a cyber-attack has damaged their brand.

Among the countries and organisations covered by a report from the Ponemon Institute (Ponemon), the average number of records lost or stolen per data breach ranges from approximately 19,000 to nearly 30,000, with the United States, India, and countries from the Arabian region experiencing the highest averages. Ponemon has concluded that the global average cost of a data breach in 2014 was $3.79 million, with a global average cost of $154 for each lost or stolen record. These costs vary geographically. For example, the average

cost per record in the United States was $217, whereas the cost was $56 per record in India. Costs also varied by industry.

Cyber risks pose threat to critical infrastructures of the nation; such critical infrastructure or the system of financial intermediation which is the backbone of commercial and economic activity that takes place incessantly. Therefore, the dynamics in cyber risk insurance is all about interaction between the main actors such as the government, the insurance companies and the regulators and between the firms who wish to seek covers against risky incidents. The growth and deepening of the sector will follow with the ability of the insurer to undertake, rate and design fair policies so that the insurance contracts are placed efficiently, tackling the problems of exactness of losses, appropriateness of claims, removing the informational asymmetries, demarcating the liabilities and considering interconnectedness of the new found risks. Such covers would need to evolve from first party to emergency response and would require addressing on issues concerning:

1) Estimation of market size for cyber insurance.
2) Drawing up of cyber insurance program with specific 'Scope' of risks defined and covered.
3) Cyber insurers could be thought leaders in the space of IT security awareness and disseminating best practices.
4) Cyber risk claims management i.e. loss assessment, reporting mechanism and claim admission needs to be properly marked.
5) The legal framework needed to foster cyber risk insurance.

Cyber Risk's- Do They Fair on the Insurability Criteria?

Berliner[7] introduced a simple, yet stringent and comprehensive, approach for differentiating between insurable and uninsurable risks. This approach, which is based on nine insurability criteria, is frequently used to analyze insurance markets and products.
The criteria are categorized into three broad categories that classify risks in terms of actuarial, market, and societal conditions (see Table). Qualifying as insurable in the actuarial category requires independence of risks and reliable estimation of loss probabilities (randomness of loss occurrence), manageable maximum possible losses per event in terms of insurer solvency (maximum possible loss), moderate average loss amounts per event (average loss per event), a sufficiently high number of loss events per annum (loss exposure), and no excessive information asymmetry problems (i.e., moral hazard, adverse selection). The actuarial criteria include the law of large numbers, which is a central paradigm in insurance economics and, briefly stated, means that the larger the number of mutually independent and identically distributed risks in a risk pool, the lower the variance of losses in the risk pool.

Insurability Criteria and Related Requirements According to Berliner

Insurability Criteria			Requirements
Actuarial	1	Randomness of loss occurrence	Independence and predictability of loss exposures
	2	Maximum possible loss	Manageable
	3	Average loss per event	Moderate
	4	Loss exposure	Loss exposure must be large
	5	Information asymmetry	Moral hazard and adverse selection not excessive
Market	6	Insurance premium	Cost recovery and affordable
	7	Cover limits	Acceptable
Societal	8	Public policy	Consistent with societal value
	9	Legal restrictions	Allow the coverage

We now derive our understanding of cyber risks in the light of the insurability criteria and how insurers need to analyze them before contemplating on insuring them:

Actuarial Criteria of Insurability Condition

1. *Randomness of Loss Occurrence*

The independence condition is an important precondition to insuring any type of risk. In the case of cyber risk, several authors find this principal assumption to be violated; this is because incidents of attack would be highly correlated among firms. Similarly regarding the cyber attacks the present or past data can provide no guidance to the future and as such loss occurrence and probabilities would be difficult to gauge.

2. *Maximum Possible Loss*

If the insurer limits himself to a certain limit without harming his solvency then this would not pose problem. During the initial phases the regulators would have to clear such products that limit the insurer's liability to the extent which he can bear without solvency pressures.

3. Average Loss Per Event

It would be challenging to derive costs based on this criterion, because cyber portfolios are very meager in our country, we would therefore have to rely on the insurers in the developed countries and study the framework vis-à-vis per event loss and draw and average figure based on proper estimates.

4. Loss Exposure

This would depend on the nature and function carried out by the industry in the networked space, typically banks and financial companies with cyber presence would have higher exposure. Loss exposures could be ascertained easily since the digital data regarding transactions could be quantified without much difficulty.

5. Information Asymmetry

Information asymmetry arises due to insurers lacking vital information regarding applications, software products installed by users, and security maintenance habits, which correlate to the risk types of users, and users hiding information about their reckless behavioral intentions from their insurers, after they get insured. This problem could be overcome by proper incentive mechanism.

Market Criteria of Insurability Condition

6. Insurance Premium

Premiums for cyber insurance may not be actuarially fair in the initial stage however as the market deepens the convergence would be right and the pricing would become fair. Competition in the cyber insurance space can also be beneficial to the firms. With participation of all kinds of firms such as large, small and medium would help to increase cyber portfolios.

7. Cover Limits

The cyber risks are intertwined and no firm or an insurance company can actually predict the amount of loss from a certain events, it is therefore better to have cover limits in place that define the liability of the insurance company and save from unnecessary litigation.

Societal Criteria of Insurability Condition

8. Public Policy

To meet the societal criteria, coverage is required to be in accordance with public policy and societal values and with the legal restrictions governing coverage. Compliance with the public policy criterion includes, among others, not issuing insurance policies for trivial risks and making sure that policies provide no incentive for criminal actions.

9. Legal Restrictions

Legal restrictions involve the types of activities an insurance company is permitted to engage in and prohibitions against insuring certain risks. The stability of the legal framework in a particular country is another important condition that must be met to make a risk insurable.

Cyber-Space Governance in India

The role of the government is immense in developing a system of cyber defense for the entire nation. The Government of India has taken several steps to tackle the menace of cyber attacks and important institutional arrangements made. The Indian Computer Emergence Response Team (CERT-In) has been established which monitors Indian cyberspace and coordinates alerts and warning of imminent attacks and detection of malicious attacks among public and private cyber users and organizations in the country. Banks / Financial Institutions[8] have been identified as critical infrastructure for the purpose. A National Cyber Coordination Centre has also been established.

It is mandated by the Information Technology Act that periodic IT security assessments are held to determine acceptable level of risks, consistent with the criticality of business/functional requirements, likely impact on business/ functions and the achievement of organizational goals/objectives. This is also documented in the *'Information Security Policy for Protection of Critical Information Infrastructure'* of CERT-In.

In 2008, the Information Technology Act 2000 was amended with the introduction of Section 70A and 70B. Article 70A mandated the need for a special agency that would look at designated "Critical Information Infrastructures" (CIIs) and evolve practices, policies and procedures to protect them from a cyber-attack. On January 16, 2014, the Department of Information Technology (DIT) issued a notification announcing the creation of a specialized body to protect India's CIIs; banking and finance sector being one of these CIIs[9]. The National Critical Information Infrastructure Protection Centre (NCIIPC) was created and placed under the technical intelligence agency, the National Technical Research Organization, to roll out counter-measures in cooperation with other security agencies and private corporate entities that man these critical sectors.

Insurance as a Response to Cyber Risks

Faced with the risk of cyber attacks, the prospect of losing data and the potential for large fines, the private sector has turned to the insurance industry to protect against losses arising from all manner of information security incidents. Allianz estimates the total written premium for cyber insurance could reach $20 billion[10] by 2025. In wake of the volatile and capricious nature of cyber attacks, the insurance companies will be keen to insure those companies that have capacity to respond to multiple incidents simultaneously and have the requisite policies for tackling with the range of potential incidents.

Making India Ready for Cyber Risk Insurance

Cyber attacks and related cyber risks have clear and present implications for the economic value creation, exchange, and transfer as well as economic destruction at all units of analysis. Shareholders and investors in publicly held firms, for instance, have to contend with market fraud such as insider trading and problems with financial reporting[10] that threaten the integrity of financial markets in normal course. Given increasing criticality of cyber attacks, now they also have to contend with cyber risk that threatens economic value creation, exchange, and transfer. We would therefore require a new set up for developing a cyber risk insurance marketplace by understanding:

a) The cyber risk landscape is ever evolving and dynamic, as a result, need is felt to have national level surveillance agencies aiding the sharing of information with all insurers who intent to develop proper models for insuring such risks.

b) Reporting mechanism of breaches to a notified agency.

c) The legal underpinnings of information security should be strengthened further in all participants who form part of the electronic commerce ecosystem.

d) Prospective cover seekers to follow guidelines properly on data protection and information security management practice as outlined by the Government and Regulators.

e) At the initial stage insurers would not be able to cover the whole spectrum of risks associated with catastrophic losses and would be selective in their outlook.

f) Insurance seekers would have to develop, adhere and exhibit high level of information security standards for continued insurability.

Part 2

(Developing Robust Foundation for Cyber Risk Insurance Marketplace)

Cyber Risk Insurance – A Growth Industry Fraught with Challenges

Unlike the western world, cyber liability and related covers for data and IT security breach are in nascent stage in India. There is not enough awareness among institutions that have forayed into the digital world and they lack coherent risk mitigation policies and infrastructure within the organization in case such vulnerability materializes. The various institutions that have digital presence are at different levels of maturity on IT security aspects and the vulnerability to such incidences of cyber related crime are on rise. The CERT reports that over 8000 websites were hacked[11] in the first quarter of 2016. In India, institutions with small or large IT infrastructures have to take covers through brokers and only fifty such policies have been sold so far. With the advent of the internet of things, billions of devices be they medical, automobile, farming or transporting equipments would be possibly handled and controlled remotely with aid of sensors. The internet of physical things can also potentially be hacked with malafide intention and cause a greater damage to society.

Cyber insurance is deemed to have the potential to make a positive impact on cyber security. Wherever cyber insurance is sold the current situation of high premiums and relatively low coverage ceilings prevail, but this is likely to change as more data are gathered about the scale of the problem by the entities involved[12]. Over time, insurance companies are expected to fine-tune the most effective ways to reduce cyber risks and organizations may be incentivized through premium reductions to listen and take action. But for this to take shape there is need for robust foundation for cyber insurance.

According to Gartner, global IT spending will reach $3.5 Trillion[13] in 2017. In the context of building enterprise resilience to counter evolving cyber threats, insurance should not just be seen as a financial instrument for transferring risk from one balance sheet to another. Importantly, the actual process of seeking cyber insurance coverage should also be viewed as the catalyst for driving an enterprise-wide risk management approach, and ultimately an improved security posture. It can bring all relevant stakeholders together in the firm such as IT, Legal, Risk Management, R&D, Finance, Human Resources, and Communications etc.

Estimation of Market Size for Cyber Risk Insurance

According to a PwC report[14]- Worldwide, the cyber insurance market will triple in size to $7.5 billion in annual premiums by 2020 but the high cost of coverage and restrictive conditions on policies may restrict growth. The report further says that businesses across all sectors are beginning to recognize the importance of cyber insurance, with 61% of corporate leaders now seeing cyber attacks as a threat to the growth of their business. There was an average of 200,000 global cyber security incidents a day in 2014. The market is still relatively untapped. While some 90% of cyber insurance is purchased by U.S. companies, only around a third of U.S. companies have some form of cyber coverage. In the United Kingdom, for example, only 2% of companies have standalone cyber insurance.

> The Government of India has taken several steps to tackle the menace of cyber attacks and important institutional arrangements made. The Indian Computer Emergence Response Team has been established which monitors Indian cyberspace and coordinates alerts and warning of imminent attacks and detection of malicious attacks among public and private cyber users and organizations in the country.

The much bigger and tougher challenges are the new exposures arising from the technological evolution of risk and how this impacts existing lines of business. The framework for that needs to deal with in-house computer systems, cloud storage, industrial control systems[15] (including artificial intelligence and the Internet of Things), and finally, national critical infrastructures, which are the biggest challenge in terms of the physical risks, and business interruption losses. India's ecommerce business is booming, Morgan Stanley Research has revised the estimate of India's ecommerce market till 2020 from $102 billion to $119 billion, this takes the estimate of the total Indian Internet market size from $137 billion to $159 billion[16] (now including online food aggregation business).

An Overview of Digital Maturity in India

India is poised to be a digitally powered country. E-Commerce is the new buzz for Indian entrepreneurs as lot of businesses and services have set up websites and portals to cater to various needs of the consumers, they include financial institutions like banks and insurance companies, retailers, manufacturers and aggregators. The move has empowered the customers with proliferated choice. This has also increased the speed and volume of transactions and has been able to remove barriers to information regarding aspects of cost, quality or features of the product/services.

The Government of India has also been a key driver of the IT revolution that is currently happening in the country. The flagship "Digital India" initiative aims at availing digitizing of various individual projects of all central government and ministries like education, health services and other services, that can be delivered to citizens using Information and Communication Technology (ICT) by joining all the areas of India including the Gram Panchayats at high speed internet through broadband connectivity, in order to focus on the e-governance till 2019. It can also be viewed as the next step of already running National e-Governance Plan[17]. In this program government will prefer to adopt Public Private Partnerships (PPP) wherever feasible for execution of this initiative.

- Cyber security has emerged as an important area of attention, particularly for the government, public and private sector. Cyber risk insurance can underpin its development with proper incentives.

- Cyber incidents are increasingly shifting towards targeting of financial institutions instead of end users. A manifestation of this trend is evident in 'Carbanak', major advanced persistent threat (APT) attack against financial institutions around the world largest banks' resulting in harm. (Carbanak- Eastern European hackers gang)

- Cyber risk cannot be brought down to zero. Hence a quick restoration plan with least damage post breach is crucial. There is a need to evolve a blueprint of coordination between financial institutions and public authorities in such an eventuality[19].

Looking at the pace of progress in digitalization and internet technologies, the current pace level for India provides a great opportunity for the insurers, however, challenges prevail. The insurance industry will have to weigh both the opportunities and challenges and come out with a sustainable

solution not only in terms of viability of the line of insurance but will also have to chalk pathway to cyber safety and security methods for the entire industries. Just like the health insurers monitor and handhold their policyholders for fitness so would the cyber insurers have a cause for largely influencing the information security and data protection policies in the country. They will play key role in disseminating education on how the incidents could be properly handled and also be averted with lesser harm.

Cyber Risk Insurance vis-à-vis the "IndiaStack"

In the Indian perspective we need to analyse cyber security from a different angle wherein many forces have converged together to reinforce India's digital dream. The chief forces amongst them are the Unique Identification Authority of India (UIDAI), the Indian Government and entities in public and private sector who aim to built a network of interaction among the service producers and consumers to fasten progress of digital provision of services, cashless economy etc.

The "IndiaStack" a set of Application Programming Interfaces (APIs) that allows governments, businesses, startups and developers to utilise the unique digital infrastructure to solve India's hard problems towards presence-less, paperless, and cashless service delivery. With this approach India is poised to become a data rich country in the next five years. The set of open API for developers includes:

- The Aadhaar for authentication
- The e-KYC documents that have been generated
- Digital lockers
- e-signatures (software based as against the present dongle based e-signs)
- The Unified Payments Interface which rides on top of the National Payment Corporation of India's Immediate Payment System.

Cyber risk insurance can aid the growth of service providers and service users on this platform provided they create an environment of trust in the mind of the providers and consumers. Insurance can also be an opportunity in developing awareness for data protection and taking the efforts to new level.

Cyber Risk Insurance - Dealing with Moral Hazard

In response to the coverage gap global insurers have begun underwriting cyber-risk insurance policies to specifically address the perils of ecommerce. These policies range from coverage for losses and fines associated with data breach notification statutes to comprehensive indemnity from consumer class action suits, infrastructure remediation costs and credit monitoring for affected individuals[19]. Similar to established lines of insurance, however, cyber-risk coverage is not immune from the traditional vulnerabilities of the insurance marketplace including moral hazard and adverse selection.

However, information exchange between insurers and regulators would help to effectively price cyber-risk coverage and thereby reduce the moral hazard presented by insured's with insufficient information-security infrastructure. Admission to this information exchange is predicated on two conditions: First, an insurer must pledge to discount premiums for entities that employ information-security infrastructure that sufficiently protects consumer custodial data as matter of public policy and second, insurers writing cyber-risk coverage must contribute their own loss data to this information exchange.

In the developed countries, cyber insurance has been around for quite a while, but without any real offerings from the insurer. The reason behind this is lack of data regarding the incidence in cyber-attacks that are now being captured by specialized agencies and companies, who are in position to assess them, quantify them and help insurers to actually put the data to use and chalk out models that would price and rate insurance covers with efficacy[20].

How Cyber Risk Insurance Coverage be Tailored

It is intended to have a cyber insurance policy to cover first-party and third-party liability coverage to organization when cyber-risk materializes and or cyber security controls at organization fails.

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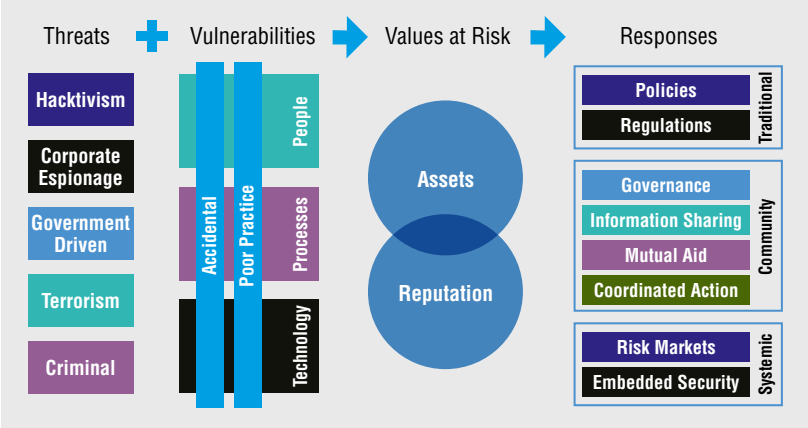


Image[22]

The coverage established by the cyber insurance shall cover property, theft and liability as represented in below section:

1. Identify the key assets - "What you are trying to protect?"
2. Identify threats to these assets - "What can go wrong, also through deliberate action by an attacker?"
3. Identify vulnerabilities that make it more likely that the threats actually materialise
4. Identify and verify the countermeasures that are in place to mitigate the vulnerabilities
5. Balance (4) against (2) and (3) to determine if the residual risk is at an acceptable level[21]

Can Cyber Risk Insurance Reboot Information Security?

Insurers could be thought leaders in the space of cyber security, the readiness or minimum eligibility condition for insurability prescribed by the insurer would require that the firms are IT security aware and adopt best practices and implement them. The firms seeking cyber insurance will have to constantly study the threat landscape and will have to understand and identify:

- In the wake of technological innovations what operational risks their business is exposed to and what kind of business continuity and disaster recovery planning is important for it.
- Development and implementation of business continuity and disaster recovery plan in the face of cyber risks.
- Identifying key procedures when activating the disaster recovery plan.

Business continuity planning in the wake of cyber attacks would require that the organizations do not rely on cyber risk insurance alone but incentives are created in such way that firms take necessary steps to build moats around the cyber risk they face.

- A framework for studying threat landscape which are likely to have implications for security and by setting up a supervision program.
- Establishing policy for determining how the institution will manage and control identified risks; creating domain specialization about the same and does reviews of recommendations received.
- Operational risk management and business continuity aspects will have to be drilled down thoroughly through the lens of IT to make the continuity planning robust.

Thus from the insurance principle, it is desirable to insure those firms who follow the best practices from security point of view:

- Where unauthorized access to networks and databases is not allowed and wherever permitted, these are through well-defined processes.
- Responsibility over such networks and databases should be clearly elucidated in proposal forms and with guidance to technology partners and vendors invariably resting with higher management.
- Institutions collecting sensitive customer data must identify themselves as the custodian and trustees of such data and must have proper framework for its protection and safeguarding of interests of their customers.
- Institutions must have a cyber crisis management plan that should address the aspect of detection, response, recovery and containment in case of any attempt or actual breach of data.

Part 3

(Cyber Risk Insurance: Policy Prescriptions)

Creating the Cyber Risk Insurance Marketplace

To overcome the frictions that impede cyber insurance and other risk transfer mechanisms, the government has an important role to play in promoting cyber resilience. By reshaping incentives and increasing awareness of cyber threats. The government could nudge the private sector into improved market-led solutions[23]. Two areas in particular stand out: information capture and dissemination about cyber threats and

losses; and setting the legal framework. The government due to its enormous power over intelligence and information has a good leverage for creating systems for sharing leads on cyber incidences, through public private partnership and can set the stage on which the actors of cyber insurance can play their designated roles. The government can also provide standard guidelines of cyber security to promote cyber hygiene.

Another area where government can play the role is by developing a legal framework for conciliation of cases involving cyber incidences. Government can also initially provide certain incentives to firms on premiums, the presence of government in the mechanism can be a great booster of confidence that will create trust in the mind of cyber policy holders. The scope of the exposures in cyber insurance is too broad to be solved by the private sector alone. Not all causes of loss can be transferred to an insurance policy, for example a cyber attack may cause physical damage to a manufacturer or utility. For example, a December 2014 malware attack to a German iron plant caused fire damage when a furnace's controls were compromised[24]. Therefore in developing a cyber risk insurance market initially would be under the guidance and aegis of the government who would be instrumental in providing:

- Standardized coverage terms and conditions regardless of which insurer is issuing the coverage.
- A nationwide database or clearing house for data breach information, specifically recording how each breach occurred and who was responsible for the breach, could be helpful to the insurance market generally and for businesses that are implementing their own data protection practices, processes, and protocols[25].
- Flexible and Industry-Specific Data Protection Guidelines

Capacity Ramp up for Cyber Insurance

In the U.S. the cyber insurance market is driven largely by the breach notification laws that are in place, currently 46 states have breach notification laws. The law drives responsibility on the part of organizations that have data breaches relative to what they must do under the law; and is the force behind the proliferation of cyber insurance in the U.S.

Similarly, there should be comprehensive Data Protection Law in place, huge volumes of data are being created daily on incessant basis; there is also transfer of data occurring between international borders. In wake of this it is felt to have a comprehensive piece of legislation dealing with data privacy or personal data protection. The Information Technology Act, 2000 (IT Act), provides for general obligations for the collection, transfer and use of personal information and also regulates several other aspects of information technology including e-commerce and cybercrime. The ISO 22301 specifies the requirements for a management system to protect against, reduce the likelihood of, and ensure one's business recovers from disruptive incidents.

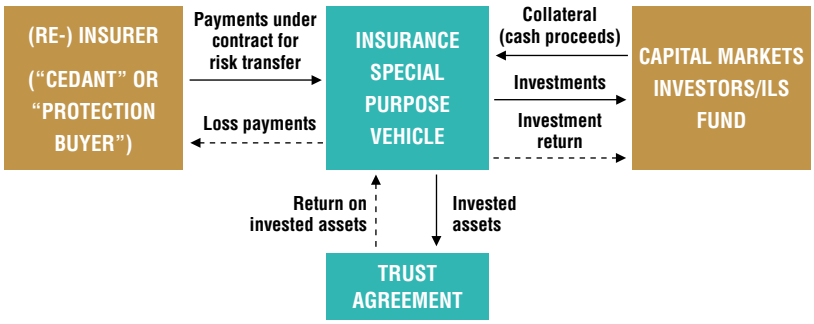
The recently announced European Union's General Data Protection Regulation which will come into force on 25 May 2018, is aimed at big corporations who collect and use increasing volumes of personal data, the new law will apply to any company that processes data in Europe, or offers goods and services to European citizens from outside Europe. In respect of data security breaches, the law provides for fines of up to 4 per cent of annual worldwide[26] turnover or EUR 20 million.

Cyber risks are real and are constantly evolving with technological advances and pervasiveness, be they individuals, small business or multi nationals—all might face a Cyber incident that can result in costly financial consequences. In times of heavy competition in classic insurance products and negative interest rate headwinds limiting returns from insurer's bond portfolios, Cyber risk presents a major opportunity for the insurance industry. With annual growth rates of up to 100%, global Cyber insurance[27] market size predictions for 2025 range between $ 10 to 20+ bn. However, at this time Cyber also presents a risk least understood by the insurance industry (and beyond).

Creating Cyber Reinsurance and Pools as Backups

It is important to have backups in the form of reinsurance where government helps the insurance industry fund the extreme losses of cyber-attacks, as an example, government takes responsibility for risks above a point. Below that point normal insurers write cyber policies which help spread information and best practice and bear the risks up to ₹ X million on any single incident or ₹ Y million on combined incidents. Reinsurance helps form successful commercial insurance markets by providing assessable mutuality for random events[28]. Cyber Reinsurance can increase supply by spreading large losses and, over time, playing a role in establishing a body of

The basic structure for an ILS deal



Source: Insurance Linked Securities Consultation, HM Treasury

data to support more accurate pricing of the risk. It also helps demand by promoting an understanding of cyber risks and the value of defending against them.

Risk Transfer Mechanism to Capital Markets

To increase the overall loss-absorbing capacity for cyber risk is to develop an investment vehicle that enables investors in capital market to take some of the exposures. Like in the early days of the hurricane risks. Insurance and reinsurance alone cannot manage the private capital side there will be an opportunity for the capital markets to play its role, where cyber risk becomes catastrophic –the capital markets could potentially play an important role. Various research papers suggest the global cost of cyber attacks has already surpassed $300bn and that actual exposures[29] could be in excess of $1 trillion and that Insurers' balance sheets are not sufficiently large to cope.

The insurance linked security is yet to become a feature of the Indian capital markets, we shall need a mechanism wherein capital market investors could be allowed to buy these securities and transfer some risks to those who are eager to have them.

What Could Cyber Risk Insurance Actually Cover?

Cyber risk insurance is particularly essential for small to medium enterprises (SMEs), whose entire capital can be wiped by a single cyber-attack. Furthermore, as compared with larger enterprises, SMEs have inadequate cyber security resources to protect themselves against soaring attacks, and are being disproportionately targeted by cyber criminals. Agreeing with this notion, a report by the Aberdeen Group estimated that when compared with larger enterprises, SMEs are 35% more likely to be targeted by cyber-criminals[30]. Cyber insurance protects a business against internal and external losses from cyber related breaches, such as:

- business disruptions costs
- replacement of impaired digital assets
- legal expenses and regulatory fines
- forensics and incident remediation
- third-party damages
- customer fraud protection
- customer communications

US retail giant Target held approximately $USD 100 million worth of cyber insurance cover by the time of its highly publicised 2013 data breach, helping offset a significant portion of the ensuing losses (approx. $USD 250 million).

The Case for Cyber-Insurance

Apart from the obvious benefit of absorbing financial impact of security risks, further reflection on the insurance approach yields three additional advantages:

- The insurance companies are likely to differentiate premiums according to different classes of risk. This creates concrete incentives to invest in secure technology.
- It becomes possible to express the value of security measures in monetary metrics. Further implications, such as comparability and the ability to apply well-understood decision methods, are corollaries of this improved quantification.
- As part of their risk management, insurance companies have to gain information about the characteristics and the extent of individual risks in order to assign adequate premiums. The better they are informed the more competitive they are. Hence, insurance companies have an incentive to reinvest a fraction of their revenues to improve their base of information, which finally leads to ever better supply of coverage[31].

Cyber Risk Insurance and Cyber Security: The Way Ahead

Effective cyber-risk monitoring focuses on building a sustainable and resilient approach to assess intelligence inputs from various functional teams and to correlate and dynamically adjust in real time the organization's risk posture. Today, a financial institution's cyber perimeter extends to locations

where data is stored, transmitted, and accessed—by internal employees and trusted partners. Most financial institutions' threat-analysis efforts are scattered across several functions, physical locations, and systems.

For a firm it is needed to have a team with right knowledge, expertise, and influence to advance cybersecurity[32] measures.

Premiums for the same insurance liability coverage amount differ between industries and organizations because risks and Cyber defense vary. The premiums for two hospitals of the same size could differ by several thousands of dollars because one has a better Cyber defense than the other. A breach at a retailer could lead to an overall increase in premiums for all retailers. So before buying a stand-alone Cyber insurance, any organization should invest some time understanding its Cyber risks and defense. The insurer will do the same[33].

Implement an effective governance structure, maintain board engagement and produce appropriate information security policies which should include[34]:

- User education and awareness training
- Monitoring policies and procedures for all networks and systems
- Incident management procedures, including response and disaster recovery
- Network security policies and procedures
- Management and control of user privileges
- Secure configuration guidance
- Malware protection procedures
- Control of removable media usage
- Monitoring of mobile and home working procedures

Conclusion

The cyber insurance market should continue to grow as a result of high profile breaches. Firms can significantly improve their risk practices by adopting common cyber risk management practices. Insurers and reinsurers are actively learning more about these risks and the underwriting process is expected to get better. As the market matures, capital markets may lend a hand in the expansion of capacity for cyber reinsurance as deals become more economically attractive. However, it should be recognized that there are limits to the role that insurance can play for managing the threat of cyber attacks. Sole reliance on insurance as a solution can create moral hazards by reducing incentives to actively manage the threat of cyber attacks. In the case of cyber warfare, cyber terrorism and government sponsored cyber attacks, public solutions may be needed, with governments assuming responsibility as the reinsurer of last resort[35].

Exhibit I

(Categories of Cyber Risks, Cebula and Young – 2010)

Category	Description	Elements
Actions of People		
1.1 Inadvertent	Unintentional actions taken without malicious or harmful intent	Mistakes, errors, omissions
1.2 Deliberate	Actions taken intentionally and with intent to do harm	Fraud, sabotage, theft, and vandalism
1.3 Inaction	Lack of action or failure to act upon a given situation	
Systems and Technology Failures		
2.1 Hardware	Risks traceable to failures in physical equipment	Failure due to capacity, performance, maintenance and obsolescence
2.2 Software	Risks stemming from software assets of all types, including programs, application and operating systems	Compatibility, configuration management, change control, security settings, coding practices and testing
2.3 Systems	Failures of integrated systems to perform as expected	Design, specifications, integration, and complexity
Failed Internal Process		
3.1 Process design and/or execution	Failures of processes to achieve their desired outcomes due to poor process design or execution	Process flow, process documentations, roles and responsibilities, notifications and alerts, information flow, escalation of issues, service level agreements, and task hand-off
3.2 Process controls	Inadequate controls on the operation of the process	Status monitoring metrics, periodic review, and process ownership

Category	Description	Elements
3.3 Supporting process	Failure of organizational supporting process to deliver the appropriate resources	Staffing, accounting, training and development and procurement
External Events		
4.1 Hazards	Events, both natural and of human origin, over which the organization has no control and that can occur without notice	Weather event, fire, flood, earthquake, unrest
4.2 Legal issues	Risks arising from legal issues	Regulatory compliance, legislation and litigation
4.3 Business issues	Risks arising from changes in the business environment of the organization	Supplier failure, market conditions, and economic conditions
4.4 Service dependencies	Risks arising from the organization's dependence on external parties	Utilities, emergency services, fuel and transportation

The premiums for two hospitals of the same size could differ by several thousands of dollars because one has a better Cyber defense than the other. A breach at a retailer could lead to an overall increase in premiums for all retailers. So before buying a stand-alone Cyber insurance, any organization should invest some time understanding its Cyber risks and defense. The insurer will do the same.

Exhibit – II

The following are the modeling methods currently employed by insurers to assess cyber risks.

a) **Monte Carlo Method –** Is a problem-solving technique used to estimate the probability of certain outcomes by running trial runs, called simulations, using random variables. A Monte Carlo simulation allows an analyst to quantify the uncertainty in an expert's estimate by defining it as a probability distribution rather than just a single expected value.

b) **Behavioural Modelling –** Is a technique which stresses the importance of human behaviour when designing, building and using cybersecurity processes. It builds on illustrating how behavioural science offers the potential for significant increases in the effectiveness of cybersecurity.

c) **Parametric Modelling –** Uses parameters to define a model. In statistics, a parametric model is a family of distributions that can be described using a finite number of parameters.

d) **Baseline Protection –** Centres on achieving an adequate and appropriate level of security for IT systems. It is a methodology used to identify and implement computer security measures in an organization.

e) **Delphi Method –** A forecasting or decision-making technique that is used to add predictive analysis.

f) **Certifications –** Can be used as a means to complying with security standards, as well as global and local rules and regulations. These guides offer general frameworks as well as specific techniques for implementing cybersecurity.

The concept of cyber value-at-risk is based on the notion of value at risk, widely used in the financial services industry. In finance, VaR is a risk measure for a given portfolio and time horizon defined as a threshold loss value. Specifically given a probability X, VaR expresses the threshold value such that the probability of the loss exceeding the VaR value is X. The curve is the normal distribution of the risk, N days is the time horizon, the X axis is the performance of the portfolio and X represents the VaR threshold. (100 – X)% is the probability of not exceeding the VaR value.

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Abstract

As health systems across the world set out to achieve the objective of Universal Health Coverage (UHC) for their population, the increasing role of efficient and sustainable risk pooling mechanism cannot be over-emphasised. High income countries mostly rely on public spending (government revenue based financing) to provide financial protection to the population. Middle and low income countries due to various constraints fail to implement government revenue based financial protection schemes. As a result, health scenario in these countries is often characterised by high out-pocket payments which warrant an effective mechanism for health protection.

Private Health Insurance market can play various role along with government revenue based schemes. Some developing countries such as India have rolled out schemes that involve private health insurance along with government revenue based systems in reducing out-of-pocket payments with promising results. A significant share of out-of pocket payments is due to out-patient healthcare needs. However, most conventional Private Voluntary Health Insurance (PVHI) and even newly

introduced Government Sponsored Health Insurance Scheme (GSHIS) provide only hospitalisation benefits. Hence it has been argued by experts private insurance in these countries have to take a leapfrog and move beyond in-hospitalisation products, to break into the less explored market of preventive and out-patient care. In doing so insurers can capitalise on new capacities generated after opening of insurance market in 1999 and detariffing in 2007-08. Enabling factors like better provider network, regulatory mechanism and technologies facilitate this move. Moreover, this also require that preventive and out-patient services be designed in line with changing disease profile of the country so that products could be of highest relevance to the consumers. This provides an opportunity to insurers who are a marginal player in healthcare expenditure to become a dominant player, as also from a minority stakeholder in healthcare industry to a majority stakeholder. It also provides an opportunity to expand market which is increasingly becoming constrained and fiercely competitive due to the entry of new players and reliance on only in-hospitalisation products.

Existing literature in this regard in the form of white papers, published industry reports, knowledge papers etc. recommend a framework for integration of preventive and out-patient services into health insurance and product designing. All earlier attempts by various stakeholders curtail the focus of approach to well-off urban population with willingness to pay because it is assumed that entire system can operate under fragmented populations and that industry can innovate while remaining dissociated from rest of the population who cannot pay. However, this must be noted that wider goals of sustainable health financing cannot be made with fragmented pooling and focussing only on those willing to pay can distort the market.

The objective of this paper is to introduce the role of private health insurance in providing effective financial protection to population by integration of out-patient and preventive services in insurance. The paper builds upon the earlier framework suggested by group of industry experts. However, this has to be done while ensuring a healthy growth for health insurance and also with increasing convergence with the public health system of country. In partnership with government just like government sponsored health insurance schemes, coverage and benefits of outpatient products must be extended to underserved areas and population with low paying capacities. This would ensure that while industry realises the full potential of market, wider goal of UHC can also be achieved at the same time.

1. What is Health Insurance?

The Organisation for Economic Cooperation and Development (OECD) defines "Health Insurance" as a way to distribute financial risk associated with the variation of individual's health care expenditure by pooling costs overtime (prepayment) and over people (pooling) (N & Colombo, 2004).

Health Insurance (HI) thus works on a mechanism of risk pooling and risk distribution. In this everyone pays a sum called 'premium' to transfer their risk of falling ill and consequent expenditures on treatment. Insurer manages the pool and distributes the risk over this pool. In event of risk realisation, when illness occurs, insurer is liable to pay the losses incurred in form of healthcare expenses to insured. This risk transfer arrangement is governed by an explicit or implicit contract between the parties (insured and insurer and agencies if involved).

1.1 Various Types of Pooling Mechanisms

Pooling mechanisms can be analysed depending upon how risk is being pooled, how pool is being managed, who is paying the premium, who is covered, mode of premium payment and implicit or explicit nature of contract. Based on this, various types of risk pools arrangements can be described namely:

a) Tax Based Funded (TBF) system

b) Social Health Insurance (SHI)

c) Private Health Insurance (PHI)

Each of these arrangements evolved as a measure to provide financial protection from health expenditure. And all Health Financing (HF) models essentially involve some degree of risk pooling. In other words, all health financing mechanisms involve elements of health insurance. *Thus the question arises as to which is the best method of health risk pooling?*

No country relies solely on any one type of financing mechanism. A country may use any one arrangement(s) as a dominant method of health financing. Such as Britain which uses an entirely tax funded system as a dominant method and Germany where SHI is the dominant way. Similarly, PHI is the major method of HF in US.

Which arrangement is used dominantly depends upon the overall value system, income level, economic growth, political environment, ideological affiliations and preferences of the society.

However, the dominant method of HF is always accompanied by another method(s) that plays a minor role. Thus in example of UK, US and Germany cited above other methods of HF exists as minor players. Such as in UK private health insurance exists which may account for only 11% of population coverage. Similarly, in US a small share of special groups are covered under government sponsored Medicaid and Mediclaim schemes.

1.2 Pooling Mechanism in Higher Income Countries (HIC)

Tax based funded systems and social health insurance use government revenue funding as a major basis. Countries are defined as having predominant funding from government revenues if these revenues account for more than half of government health spending and government health spending represents more than half of all health spending (Shedoff, 2004). These systems have often found to be very progressive, redistributive and sustainable. Traditionally in tax based system enrolment (hence contribution) is mandatory (or statutory) by law (except few notable exceptions). Most developed (HICs) and a few developing (middle and lower middle income) nations that have achieved near Universal Health Coverage[1] (UHC) have done so by government revenue based systems. In fact, government revenues are the predominant source for health care expenditures in 106 out of 191 WHO member countries.

In the countries with TBF or SHIs as dominant method and mandatory (or statutory) coverage, varying degree of PHI market may also exist. The extent of the PHI market size, risk pool, contribution to overall health spending, and role may vary widely depending upon the degree to which a country chooses to rely on it along with statutory coverage. This is particularly true for the European Union (EU), where almost every country provides universal statutory health coverage as part of a wider system of 'social' or 'financial' protection. In many EU member states PHIs have a supplementary role. This means better choice and faster access to those healthcare services that are otherwise available under statutory coverage but with lower choices and with waiting periods. A complementary role of PHI is a more significant in the sense that it makes available, in part or full, those services which are completely excluded or covered partially (such as long term care, dental care, co-payments etc.) in statutory coverage. In few exceptional cases statutory health insurance may be absent and hence requires purchase of PHI mandated by law. Or, individuals above a certain income level can be allowed to opt out of statutory cover and must purchase a PHI as primary cover (Thomson & Mossialos, 2009)

In this context, it is of particular importance to mention that PHI can be offered by various entities (for profit and for non-profit), can allow mandatory enrolment (as in Swedish or German example discussed above), can provide varying degree of benefits and coverage and various contractual agreement with service providers for delivery of services and care. This is in sharp contrast to government revenue based model which is largely non-profit, comes with statutory enrolment (and contribution) and a much more standardised service delivery mechanisms.

> Private Health Insurance market can play various role along with government revenue based schemes. Some developing countries such as India have rolled out schemes that involve private health insurance along with government revenue based systems in reducing out-of-pocket payments with promising results.

As Barr (1992) observed that distinction between voluntary and statutory coverage is significant as many market failures are associated when coverage (enrolment) is voluntary (even if PHI is offered by a non-profit entity). This is increasingly the case when private insurance is available on a voluntary basis without any kind of statutory government revenue based cover. This is exactly the case in low and middle income countries as discussed next.

1.3 Pooling Mechanism in Lower and Middle Income Countries (LMIC)

In most of the lower and middle income countries, a mix of government revenue based pooling and private health insurance pooling exists. Yet most of these countries have very high share of total health expenditure in form of out-of-pocket (OOP) payments. Unlike OECD (or EU member) countries a

[1] Universal Health Coverage (UHC) can be defined as provision of quality health services as per need of the population without facing financial hardship as close to the population as possible (World Health Organisation, 2010).

statutory government revenue based (TBF and SHI) financing is absent in these countries. This explains ineffective risk pooling as one of major reasons responsible for high OOPs and lower financial protection. Just like OECD countries, market for PHI is present in varying extent in these countries. However, private health insurance in these countries is a case of market failure and thus fails to provide desired level of financial protection to population. PHI, otherwise, is rarely a significant source of financing for health expenditures in these countries. Nevertheless, low- and lower-middle income countries account for almost one half of the countries with PHI markets that contribute more than 5 percent to total health expenditures. In a few middle-income countries, such as Brazil, Chile, Namibia, South Africa, and Zimbabwe, PHIs accounts for more than 20 percent of total health spending (N, Savedoff, & Tripathi, 2005).

Reduction in OOPs is the most important agenda pursued by health systems in order to achieve UHC. A few mid and lower income countries exist, as notable exception, who have been able to use TBF to achieve near UHC. What stands apart here is that in doing so, these countries have spent relatively low share of their GDP compared to more developed OECD countries.

However, recently many low and lower middle income countries are using PHI as a major way to mitigate the health risk of individuals and to achieve major public health goals (Gottret, Hansl, Kalavakonda, Nagpal, & Tapay, 2012). India and Colombia are two very recent and very prominent example where this has happened (IRDAI). In these countries, governments have created arrangements where private health insurers manage the risk pool. In India enrolment is voluntary and premium is entirely paid or heavily subsidised by governments. In Colombia, enrolment is mandatory and government subsidises premium payment in part or full only for those who cannot pay. Such efforts have existed only very recently. For example in India major form of such efforts started appearing only after 2008-09. Such efforts involved private, indemnity based health insurance companies competitively selected by government to provide financial protection to targeted households (IRDAI, 2009-10). Although it is reported that smaller variants of such efforts sponsored by local communities or state governments were present as early as 2001-02. Government Sponsored Health Insurance Scheme (GSHIS) is the umbrella term coined for all such efforts in the country (Forgia & Nagpal, 2012). In the light of above discussion a working definition for private health insurance can be formed as "insurance that is taken up voluntarily and paid for privately, either by individuals or by employers on behalf of individuals (Thomson & Mossialos, 2009)." This form of private health insurance can be referred to as Private Voluntary Health Insurance (PVHI).

This definition recognises that PVHI can be offered by any entity, with or without government revenue funded statutory cover, may be associated with higher degree of market failures and still can be explored for possible roles in attainment of UHC.

Indian health scenario (as discussed in coming sections) is very much similar to lower middle income countries as discussed above. Use of PVHI and GSHIS to attain larger public health goals is a recent phenomenon with great interest. It is in these contexts that succeeding sections of the paper analyse and discuss the role of PVHI and GSHIS in reaching the goal of UHC.

2. Health Financing in India

Public health system in India is a case of chronic underinvestment. Over last few decades, India has been spending on an average only 3.5%-4.5% of its GDP on healthcare annually (The World Bank, 2017). Other countries comparable to India in terms of economic indicators (such as GDP growth rate, per capita income) typically spend higher share of GDP on health (The World Bank, 2010; WHO (World Health Organization), 2010). Over the time too, growth in health spending has not kept up with growth in GDP (MOHFW (Ministry of Health and Family Welfare, India), 2004-05).

Moreover, public spending (government revenue based) as a share of total health expenditure (THE) has remained in the range of 20%-25% only. This is abysmally low since nearly 69% of total health expenditure in India comes from OOP expenditure. Only 5%-6% of total health expenditure comes from PVHI or GSHIS (MOHFW (Ministry of Health and Family Welfare, India), 2004-05).

OOP in India (70% of THE) is one of the highest in world. From a household's perspective this means a significant share of non-food expenditure is due to healthcare expenses. In a large number of household healthcare expenditure as share of non-food expenditure can be more than 40%, when it is called catastrophic health expenditure. This has an impoverishing effect and a large number of people are pushed to poverty every year due to high OOP payments.

A large part of OOP in India is caused in form of expenditure on out-patient care (nearly 80%) and expenditure on in-hospitalisation constitute small share.

Health insurance (including PVHI and GSHIS) contribute only 5% of THE. As health insurance covers only in-hospitalisation cost OOP among insured can also remain significantly high. Health insurance due to lower contribution in overall health expenditure is a marginal player in public health (MOHFW (Ministry of Health and Family Welfare, India), 2004-05).

2.1 Reducing OOP as Focus of Health Financing in India

As discussed high out of pocket payments in India (just like any other LMIC) is due to persistently low government spending. Again, PVHI (and GSHIS) are a marginal player in contribution to THE.

One of the goals of UHC is to bring down the OOP payments to significantly lower (less than 30% of THE). Considering that a lion's share of OOP expenditure is attributed to out-patient visits, it is imperative that any attempt to reduce OOP must preferably target the provision of out-patient care.

This can be achieved by increasing the share of public share of healthcare expenditure. Indeed available policy documents and government reports express the commitment of government to increase the share of GDP on healthcare. However, this may be a long term vision and run the risk of losing focus as has happened in the past. Also, even if the public spending on healthcare is increased, this may not be sufficient as per need. Available additional resources may not be specifically targeted.

However, in past important policy documents such as 12th Plan Commission report, Commission on Macroeconomics and Health and Planning Commission Vision-2020 and mostly recently National Health Policy 2017, also re-emphasizes that Health Insurance in combination with increased public spending on healthcare can become a major way of financing healthcare in India and providing the desired level of financial protection to population.

2.2 Health Insurance: Coverages and Benefits

From a health financing point of view it is important to gauge the progress of HI in terms of coverage and benefits. Coverage is defined as total number of lives covered under health insurance as a proportion of total population during a specified period. Benefits under HI denotes the various types of service packages available and delivered as per specific terms of the insurance contract.

1. Coverage: As in 2015-16, private voluntary health insurance in India covered 85.7 million lives in India.[2] Additionally, 27.33 million lives were covered under GSHIS. This totals to 359 million lives covered under any one form of health insurance (IRDAI, 2015-16). It means approximately 27% to 28% of entire population of country (as per census 2011) is covered under anyone form of health insurance. As per an estimation approximately 228 million lives are covered under one of the state government's health insurance scheme[3]. The same estimate puts total number of lives covered under ESI and CGHS to be approximately 75 million (Forgia & Nagpal, 2012). Thus, a total of 712 million people are covered under health insurance or any other type of financial protection scheme as on 2015-16. This constitutes a little less than 60% of the population.

This means roughly 40% of population can still be covered under any one of the health insurance or other protection schemes. Of all the available schemes GSHIS has highest potential to increase coverage because increased public spending on healthcare shall create sufficient resources for premium payment under these schemes and enrolment is voluntary. PVHI has second in line highest potential to grow coverage because economic growth shall enable people or employers to pay for the commercial plans. However, NCEUS (2009) report estimates that about 23% of the population can be termed as middle income or higher income class. Assuming that all of this population can afford to purchase commercial plans the maximum growth possible for PVHI is 23% of the population.

2. Benefits: It is important to increase coverage to almost entire population. However, schemes which have highest potential to increase coverage (PVHI and GSHIS) as discussed above offer limited benefits that are far from being comprehensive. Almost all HIs cover only in-hospitalisation cost and all the products/benefits offered are variants of in-hospitalisation packages at secondary or tertiary level of care. No HI scheme offers preventive and out-patient services as a main line product. It is worth mentioning that PVHI especially standalone health insurers have started offering some products in wellness and out-patient category. However, in true sense of risk pooling pricing mechanism and benefit delivery, these products are yet to develop to be called

[2] Includes lives covered by retail health insurance as well as group health insurance (GHI) plans.

[3] In the states of Karnataka, Andhra Pradesh, Tamil Nadu and Maharashtra.

as main-line products and overall PVHI and GSHIS for all practical purposes can be considered devoid of any type of preventive and OPD products.

3. Changing Disease Profile: Epidemiological Transition

Population disease profile in India is rapidly in transition with double burden of diseases. This means that unlike developed (high income) countries where communicable disease (CDs) prevalence has come down significantly while that of non-communicable diseases (NCDs) are on the rise. In India, the prevalence of CDs may be stable or rising and at the same time NCDs are also on rise due to change in lifestyle and behavioural factors. WHO estimates that for some major NCDs (with preventable risk factors) like diabetes, hypertension, cardio-vascular diseases, India contributes significantly to their global burden. With increased life-expectancy age-related disorders and need for long term care (LTC), elderly care, terminal illness care etc is on rise. Overall, CDs contribute 28%, NCDs 60% and injuries as 12% to the country's disease burden (WHO, 2014). NCDs account for 40% of all hospital stays and nearly 35% of all recorded out-patient visits in India making them leading cause of morbidity and mortality (Shahrawat & Rao, 2012).

This has implications for everyone. For already burdened public health system it means more load in terms of higher patient volumes and visits and ever increasing need of resources. For insurers, it means rise in healthcare costs and a pool of high risk individuals with the threat to imbalance the risk distribution. For economy in general, this means rising loss of DALYs[4].

Health Insurance as a subset of healthcare industry in India which is one of the fastest growing sector of the economy. Experts have estimated a CAGR of 23% till 2020 and a market size of $280 billion for healthcare industry. HI is a minority stakeholder in a very rapidly growing healthcare industry with less than 10% share (FICCI, 2017).

Approximately 1.3% of GDP loss is caused due to increasing burden of NCDs (WHO, 2006). Intervention in the form of national programme on NCDs are in place, however, based on strategy of early detection and prompt treatment NCDs must be tackled at service delivery levels.

It is in this specific aspect there is a need for development of specialised insurance products focussing at NCDs prevention, early detection and prompt treatment. Also, insurance products which hitherto have been offering only in-hospitalisation products must diversify to offer products in LTC, elderly care and terminal illness products etc.

In line with above discussions, it is very much apparent that a need and a demand for preventive and out-patient insurance products exists in general. This is true from a consumer as well as from a public health point of view. The size of demand and consequent market opportunity can be very large. Specific products focussing on specific diseases such as NCDs and elderly care can be of higher relevance to the consumers.

4. Health Insurance: Need to Move Beyond Hospitalisation

Traditionally, health insurers in India have operated in a limited territory of risk of managing in-hospitalisation care. Although, modern HI industry is in existence for last 60-70 years in India yet little attempts have been made to move beyond in-hospitalisation care.

4.1 Health Insurance as a Marginal Player and Minority Stakeholder

Due to limited contribution (less than 5%), HI has remained a marginal player in meeting the health expenditure needs. Again HI as a subset of healthcare industry in India which is one of the fastest growing sector of the economy. Experts have estimated a CAGR of 23% till 2020 and a market size of $280 billion for healthcare industry. HI is a minority stakeholder in a very rapidly growing healthcare industry with less than 10% share (FICCI, 2017).

4.2 Growth Constraints for HI Industry with In-Hospitalisation as Main Line Product

Although HI remains second most important line of business for insurance industry contributing nearly 37%-38% to insurers' top line in 2015-16 (IRDAI, 2015-16). The scope of growth on HI market comes with a greater challenge of increasing competition amongst existing and new players. Also, profitability of HI market is likely to be threatened due to rising

[4] *Disability Adjusted Life Years.*

healthcare costs, increased negotiating power of organised sector clients (as evident by decreasing per life premium for GHIs and increasing loss ratio of GHI portfolio). As discussed earlier, some growth can be expected in retail commercial plans and GSHIS but opportunity is limited by increasing competition and external factors such as rise in per capita income which are highly uncertain factors.

This calls for urgent course correction by industry to move beyond hospitalisation products.

4.3 Breaking Into Preventive and Out-Patient Care: Opportunities and Challenges

Conventionally, HI has cited reasons for not being able to design preventive and out-patient products. These reasons as described below were valid and were a major impediment to the expansion of HI into preventive and out-patient services:

1. *Lack of data/experience for pricing mechanism:* Out-patient care is yet to be standardised. This means that underwriter find it difficult to price these products.
2. *Lack of a reliable provider network.*
3. *Inability to implement a sustainable paying mechanism:* IPD care reimburses the providers as per agreed package rates or pay as you go or actual cost basis. However, due to an entirely different type of risk, OPD products are difficult to be paid for in a sustainable manner (FICCI, 2015).

However, these limitations must be analysed in the light of new scenario of HI industry in India especially after enactment of IRDAI act 1999 and de-tariffication of insurance in 2008. Before 1999, market was evolving where very limited number public insurers with limited incentive for diversification were operating. Post-1999, insurance sector was opened up for FDI and after 2008 role of standalone health insurers and Third Party Administrators (TPA) grew in the industry. This has led to increased capacity and a vast aggregated network of health providers. Also, a number of new start-ups willing to leverage on the disruptive technology to provide a range of wellness, value added, preventive, out-patient care are available. Thus, it has become possible to overcome above mentioned barriers and break into the new domain of preventive and out-patient coverage (FICCI, 2015).

Fortunately, various stakeholders led by industry associations, insurers, GSHIS, have already started initiatives in this direction and it is high time to capitalise on existing grounds to seize the opportunity. In this direction, experience of stand-alone health insurers to provide preventive and out-patient products coupled with experience of health provider aggregators can be a starting point to design next level of products. OPD initiative under *Rashtriya Swasthya Bima Yojana* (RSBY) has provided valuable lessons in finding a suitable technology for sharing of transactions, tracking and flow of real time data that forms the backbone of industry practice (ICICI Foundation, 2013).

In short, it is high time to leapfrog by industry to move beyond in-hospitalisation products into range of OPD products. However, a larger concern that is often expressed by industry stalwarts and insurance experts remains to be addressed. This is about small ticket size and high frequency transaction of out-patient care which makes it prone to moral hazard and may even be threatened by increased abuse and fraud. This requires carefully designed products whose transactions can be tracked in an intuitive manner. This also requires increased need of sharing patient level data and electronic health record (EHR). Because, service provider industry is still largely unregulated and lacks and standardisation, it is very important that in the likely event of abuse and fraud, corrective actions can be taken. However this remains a grey area for entire health insurance industry and is still to be addressed even for in-hospitalisation products. Thus, this concern should not be a deterrent for leapfrogging.

5. Key Strategies to Move Into Preventive and Out-Patient Services

As we noted that a baby step has been taken by the industry associations in the form of research, knowledge papers and advocacy papers etc to push for policy reforms and industry's awareness. Insurers are already offering very primitive kind of wellness, preventive and out-patient products. These are initial steps toward leapfrogging. Availability of domestic start-up companies working in the area of provider aggregation, patient, data and EHR sharing and technology development provide necessary experience to build upon. On top of it, international experience has a lot to offer to India especially from countries of comparable economic status such as Brazil, Indonesia, South Korea, Thailand and Turkey (FICCI, 2015).

5.1 Pushing for General Policy Reforms and Health Insurance Regulations

Traditional indemnity based hospitalisation insurance products are essentially an annual contract which enables actual transfer of risk from insured to insurer. This contract is valid

under an existing set of regulations which has evolved over a period of time often as a precursor to industry's requirement and also as an enabler for the industry. Similarly, there exist an enabling environment for the growth of overall insurance industry as inbuilt in government policies and reforms from time to time. No industry can ever grow without a conducive ecosystem of enabling, regulatory framework and supportive government policies. It is under this set of conditions that supply side is able to cater the need of the demand side with full realisation of market potential. In case of HI, this is a pre-requisite of even higher relevance because as discussed earlier PVHI market is prone to market failure.

1. *General governance and policies:*
    i. Support for industry in the form of tax breaks, viability gap funding or Public-Private Partnership (PPP).
    ii. Emphasis on fulfilling commitment by government on increasing public spending on healthcare with focus on strengthening of primary healthcare network especially in unserved areas.
    iii. Better regulations of primary and secondary healthcare providers thereby making them accountable and bringing them under tangible regulatory laws. This is largely absent in our country and poses the single biggest threat to insurance industry.

2. *Changes in health insurance regulations:*
    i. Introduction of out-patient chronic care and elderly care products as a specific product line.
    ii. Just like enabling regulatory framework for successful role out of GSHIS on PPP mode introduction of enabling regulations for roll out of out-patient products on PPP mode.
    iii. Allowing the pricing of products on risk sharing and capitation based payment models.
    iv. Mandatory adoption, use, updation and sharing of EHR.

5.2 Healthcare Network Design Principles and Strategic Purchasing of Healthcare

Preventive and out-patient insurance products differ from conventional in-hospitalisation products in the sense that these are not actually a mechanism for risk transferring or pooling but it is a mechanism for risk sharing with providers and strategic purchasing of health care services from them.

1. *Layering upon primary healthcare network:* A general theme that emerges across the nations that have successfully implemented tax-based universal healthcare programmes is that out-patient and preventive services can be layered upon a wide network of public health facilities and this model has ability to mutually benefit both public health systems and insurers. A*ll earlier attempts by various stakeholders curtail the focus of approach to well-off urban population with willingness to pay because it is assumed that entire system can operate under fragmented populations and that industry can innovate while remaining dissociated from rest of the population who cannot pay. However, this must be noted that wider goals of sustainable health financing cannot be made with fragmented pooling and focussing only on those willing to pay can distort the market. Thus, this work realises the importance of increased coordination of insurance and public health services and that is why in preceding sections emphasis has been laid upon increasing coordination with government to reach to even unserved sections of society who have very little capacity to pay in partnership with government.*

2. *Aggregation of network providers:* In those areas easily served by TPAs and aggregators readily available network of providers is available. Compared to a few years ago this network is now pretty big and involves a range of service providers ranging from provider of preventive services (physiotherapists), wellness teams (easy chain of fitness centres, diagnostics chains, stand-alone and captive primary care service providers). In the last decade, healthcare delivery has been aggregated by TP As - there are now more than 35000 hospitals and 9000 diagnostic centres on the insured network across all TP As - with 10974 hospitals and Diagnostic centres added in 2010 alone (IRDAI, 2015-16).

3. *Closed service provider network:* Since, out-patient products would initially focus on specific diseases such as chronic care condition or elderly care, it is advisable that for better compliance and better outcomes, closed network of service providers with specialised list of primary care physicians is adopted.

4. *Gate keeping mechanism:* Physician may serve as both first point of contact and prompt care taker with

an objective to contain the diseases so that need for referral services for specialised care can be minimised.

5. *Clinical Protocols:* Standardisations of operating procedures, referral guidelines, prescription audits and need for emergency care guidelines should be in place.

6. *Strategic purchasing of healthcare services:* In form of risk sharing arrangement and capitation based payments for providers along with capitation pay for performance (P4P) and result-based financing approach can be used. For example, if group linked to the provider performs better in terms of reduction of certain risk factors or measurable improvement in health indicators or adoption of healthy practices then special payments can be made to providers in addition to fixed capitation payments (Langenbrunner, Cashin, & O'Dougherty, 2009).

5.3 Suitable Technology and Patient Data Sharing

Valuable lessons are available from RSBY out-patient experiment and technology adopted by GSHIS (state-run) has proved to be very useful and has actually served as backbone of successful delivery of OPD services on a considerable large scale.

Start-ups in the form of network aggregators, medical coding technologies, EHR database technologies are available which are being used in various health insurance related needs and can also be successfully adopted for out-patient products (MOFHW, 2016).

6. Product Design for Wellness, Preventive and Out-Patient Services

Primitive products in wellness and out-patient segment have already being offered by insurers. However these products are not rationalised with respect to pricing and does not include appropriate costing for a variety of possible risks that can vary with geographical location, nature of disease, type of care needed and longitudinal duration of risks over lifetime of the insured. That is why present out-patient products are overpriced and do not provide value proposition to the insured.

For example prevention services for a child residing in urban area may differ significantly from that residing in rural area at the same time it widely differs from those needed for elderly care and thus special pricing mechanism keeping in mind the risk sharing arrangement with provider, availability of services and probability of improvement of risk or deterioration of risk, all must be taken into account for example preventive and out-patient services are likely to be more effective for younger patients and children with improvement in risk overtime. However, risk is surely to deteriorate in case of elderly care. Similarly, risk for chronic care may be contained depending upon to what extent prevention was adopted and how early an intervention was taken after diagnosis.

Age-wise in both rural and urban areas a majority of prevention and out-patient services are either available in public health system or are available as an add-on of in-hospitalisation insurance product. For example, vaccination against scheduled communicable disease for early childhood is provided entirely free in public health services. Similarly antenatal and post-natal care are also covered in hospitalisation products as also focused national programmes exist for them in public health systems. Similarly insurance companies have started providing a range of wellness services that promote the healthy behaviour among insured and suitable reward them if overall health status improves. In this way, it can be argued that a range of services already accessed either in public health system or as an add-on to health insurance product or as a value added or wellness product.

Insurance companies have started providing a range of wellness services that promote the healthy behaviour among insured and suitable reward them if overall health status improves.

This observation and our earlier discussion suggests that majority of out-patient costs is being caused by chronic nature NCDs, as also a considerably higher elderly population exist due to increased life expectancy. Industry should start with out-patient products specific to chromic care (NCDs) and elderly care.

6.1 Product Design for Chronic Care

India's changing disease profile and its impact on health finance and economy has already been discussed in section 5. It is possible for industry to enter in a risk sharing with providers that can contain the risk associated with untreated, unmanaged chronic care. In doing so, industry can also avoid good deal of hospitalisation episodes and can save on hospitalisation losses.

A. *Listing of major cost line items:* In any chronic disease major, cost elements are cost of medicines and consumables, cost of diagnostics and consultations, cost of treating complications and supportive or rehabilitative cost. Out-patient product essentially covers these costs in a risk sharing mode with risk providers.

B. *Insured or uninsured condition of the individual at the time of diagnosis of disease:* Insured who did not have a diagnosed chronic condition when they bought coverage should be provided coverage layered upon existing health insurance plan (in-hospitalisation). Insured who had a condition at the time they bought coverage should be offered management plan with appropriate costing. Uninsured not diagnoses with condition should be offered low premium product clubbed with wellness products. Uninsured with a diagnosed condition should be offered a recurring premium product that may change depending upon compliance to the disease management protocol.

C. *General considerations along with general market conditions and suitability along with applicable exclusions and layering upon various existing health insurance products, these products can be designed and distributed.*

6.2 Product for Elderly Care

Elderly care is a vast subject and is a fully evolved market in developed countries such as US. It encompasses a number of conditions related to a specific age group of population those have run their economically productive age and are leading a dependent life. Under present Indian conditions, it is not possible to cover all elderly care needs and some other needs require a long term pooling of fund and fund management as also a specialised care under widely varied conditions of domiciliary nursing care or terminal illness centres. However, this product is of very high relevance in Indian market scenario because of changing demography and high expenditure associated with elderly care (Hore, 2016).

7. Conclusion and Recommendations

Health Insurance industry has recognised the importance of moving beyond the conventional model of in-hospitalisation risk. It has already made strives to venture into the less explored territory of preventive and outpatient care. This is expected to open up a huge opportunity for industry and other stakeholders of healthcare domain in India. Over the time it is very much possible to turn health insurers into a majority stakeholders to a dominant player of healthcare industry and also in overall insurance industry. Significant contribution can be made into the achievement of goals of UHC in India. Overall increased coverage, increased relevance to consumers need and multiplier effect of benefits HI is likely to become a subject of day to day life a common citizen just like the present day influencers such as telecom, banking and IT.

A look at the transition of disease profile of population makes it realise that preventive and OPD care are not just an opportunity for industry but also a need of the time. Increased burden of NCDs is a menace that eats into nation's GDP growth, robs households of their income and leaves insurers with an unhealthy pool of high risked individuals with recurring high end hospitalisation episodes. Addressing the challenges of NCDs requires a more complex, multi stakeholder and multipronged approach. This is a long term goal. But beyond doubt it is positive net worth action with benefits outdoing the cost by multiple times. In case of Health insurers the share of overall cost pie is even smaller but share of overall benefit pie is huge. This has been established plausibly in preceding sections.

There is little doubt about the win-win effect described above. Extent to which this is possible may be a matter of concern. As we discussed in previous sections conducive environment exists and initial reports has already been taken. Health Insurance scenario has changed with more standalone health insurance players with increased expertise. Availability of network of aggregated service providers rapidly evolving to provide bouquet of preventive and ambulatory care with increased reliance upon quality of care provided. This is augmented by greater commitment of government to roll out UHC and development of a patient centric health financing system. Technological innovation has created enabling environment for efficient transactions, effective sharing and analyses of data and improved customer servicing. Technology if not a limiting factor could be a level mover. By increased adoptability of technology it is possible to operate at entirely new levels and curves. Role of regulator

to create enabling environment and easing the ecosystem in which players operate cannot be overemphasised. Market regulator's signalling system is necessary to ensure that movement on right tracks with right speed is maintained so that sustainability is preserved.

Health insurance industry in India has an advantage of scale. It is also operating at an ascending part of growth curve in an environment which is full of potentials in terms of general economic growth, demographic dividend with a push for innovation and knowledge led growth. Attempts to roll out evidence based, marketable and sustainable preventive and OPD products are no more a challenge for Indian industry but rather it is an opportunity now. Countries which have achieved near UHC have done this mostly on a tax funded health system. Question of larger importance may be can Indian Commercial Insurance has full potential to turn into a global leader in this aspect and present a model of its own worth emulating by the rest of the world?

Recommendations

General Principles- Industry has begun and so has the government, it is high time to gain momentum from here to develop an ecosystem toward an enriched "Preventive and Outpatient Healthcare Models" with linkages to overall public health system goals and not just patchy, sporadic insurance products. Existing efforts of Industry are focussed mainly on those segment of population which has ability to pay, this shows a rather risk averse, profit oriented approach of Industry in catering to Prev and OPD needs of the population. As discussed this has capacity to distort market and inefficient outcomes may follow. Unlike in-hospitalisation risk portfolio the out-patient product could soon risks itself to run out of business. On other hand government has ambitious plans to reform the public health sector. In past this has also been visibly translated in the form of various health insurance schemes. However, these schemes may not be based on principles of health insurance of risk pooling and also lack the practice of strategic purchasing thus failing to achieve the desired objectives. Such is the case with most state government owned schemes. Schemes which involved health insurers helped to serve multiple objectives to a satisfactory extent but lack of continued support from government has resulted in decline of such schemes. Nonetheless, it is implied for market to proceed on its own as far as possible in selected segments. In other segments of population a PPP, market-government mixed approach like VGF or other innovative strategies can be worked out.

Identification of entire value chain, role of various stakeholders with clearly defined objectives and measurable progress. Collaborations will be required among various stakeholder groups such as government and industry coming together for a PPP model. As also greater collaborations shall be required within members of a specific stakeholder group such as many insurers coming together to form a common repository of patient information and EHR. Preliminary background work has been done by industry in coordination with key stakeholders and key concepts, learnings and consensus has been well documented. Time to build upon these learnings.

Focus on IPD products should not be lost but rather population coverage must be achieved to fullest possible level. However, goals should be changed to bring down the overall hospitalisation episodes and cost of care.

Aim of preventive and OPD coverage should be to create a pool of healthy individuals, bring down the level of preventable risk factors in population, gate keeping mechanism from unnecessary hospitalisation, strategic purchasing of health care services, and cafeteria approach of providing range of choices of products and services to consumer with increasing relevance to their needs. Finally, these goals should culminate into the larger objective of creating new market for sustainable growth of health insurers and bringing down OOP payments.

Specific Actionable Points

1. Pushing for policy reforms.
2. Advocating for a more favourable regulatory environment.
3. Layering on public health/ Aggregated health providers.
4. Strategic purchasing of health services.
5. Efficient utilisation of distribution channels and existing business lines to penetrate into market with least possible incremental cost.
6. Preventive and Wellness products as preferred segments than secondary OPD care or rehabilitative OPD services.
7. Focussed products for secondary OPD care such as for Chronic Illness (NCDs) and for Elderly (geriatric) care.
8. Provider payments in form of capitation or mix of capitation and RBF/P4P.
9. Sharing of patient level data and EHR.
10. Quality initiative for providers.

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List of Abbreviations

1	CD	Communicable Disease
2	CGHS	Central Government Health Scheme
3	DALY	Disability Adjusted Life Years
4	EHR	Electronic Health Record
5	ESI	Employee State Insurance
6	EU	European Union
7	FDI	Foreign Direct Investment
8	GDP	Gross Domestic Product
9	GHI	Group Health Insurance
10	GSHIS	Government Sponsored Health Insurance Scheme
11	HF	Health Financing
12	HI	Health Insurance
13	IPD	In Patient
14	IRDAI	Insurance Regulatory and Development Authority Act
15	IRDAI	Insurance Regulatory and Authority of India
16	IT	Information Technology
17	LTC	Long Term Care
18	NCD	Non-Communicable Diseases
19	NCEUS	National Commission for Enterprises in the Unorganized Sector
20	OECD	Organisation for Economic Cooperation and Development
21	OOP	Out-of-Pocket
22	OPD	Out-patient
23	P4P	Pay for Performance
24	PHI	Private Health Insurance
25	PPP	Public Private Partnerships
26	PVHI	Private Voluntary Health Insurance
27	RBF	Result based financing
28	RSBY	Rashtriya Swasthya Bima Yojana
29	SHI	Social Health Insurance
30	TBF	Tax Based Funded
31	THE	Total Health Expenditure
32	TPA	Third Party Administrators
33	UHC	Universal Health Coverage
34	WHO	World Health Organisation

Merit Winner

Technical Paper Essay Competition (Micro)

Micro Insurance : Challenges for Sustainable Growth

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Abstract

Micro insurance is a mechanism to protect low income people against risk, such as accident, illness, and natural disasters, in exchange for insurance premium payments tailored to their needs, income and level of risk. The micro insurance sector is a fast-growing industry with a potentially untapped market of over 2 billion people worldwide. Micro insurance can also be a tool to extend social protection in the context of providing security to populations in developing countries and contributing to poverty alleviation.

The Insurance Regulatory and Development Authority (IRDAI) India introduced the revised Micro insurance Regulation (2015) which supersedes the existing regulations introduced in 2005. The new regulation also saw the introduction of a new product category, Micro Variable Life Insurance Products, a hybrid insurance solution comprising of systematic contributions with term insurance cover. This product has a lock-in period of five years during which policy surrenders are not allowed, but partial withdrawals permitted.

The characteristic trait of micro insurance is assistance for the low income segment but incorporating the basic principles of the traditional insurance activity, such as regularly paid premiums, the uncertainty of the risks and the proportionality of the premiums to the risks and costs. More than 70% of the population lives in rural areas. At the same time their consumption pattern, choice and preference has changed. Technology and internet has given ample scope for rural people to adopt new ideas. Micro insurance is an avenue that has fostered growth, which has been specially designed for rural people with low premium and high coverage. People who face the greatest amount of risk are far more likely to purchase insurance than those with lower than average risk. This is detrimental to insurers, who profit when people purchase policies that they do not end up needing. In such cases, the insurance companies have no flexibility to leverage their own risks.

The challenges faced by micro-insurance schemes may be the learning lesson for the generations to come. Product development, regulatory modification, financial literacy drive, distribution optimization for insurance products are a few steps to ensure better and deeper micro insurance penetration in rural areas for people living below poverty line. If rightly implemented micro insurance schemes could bring in sea change in the living standard of rural population living below poverty line. If large insurance companies can remain attuned to regional sensitivities and scale quickly, micro insurance offers a huge opportunity for insurers to penetrate new markets and build a more resilient and inclusive economy.

1. Preface

Micro insurance is a way of developing resilience to unfortunate events; it fosters families' sustainability and the ability to overcome other hardships, including financial troubles. A theoretical dichotomy is posed by the function of micro insurance, which could be 'protective,' in the strict sense, embracing personal and family protection, with health and life products, and also could be viewed as 'productive,' on the basis of support for investment in economic activities with capital-based micro insurance tied in with crop or animal-farming work or small companies. In practice, as in the former dichotomy, both strands tend to come together in terms of protecting the poorest groups from the risks they are exposed to. Micro insurance akin to microfinance is part of the government's financial inclusion initiative to provide the necessary social security measure to the under privileged and rural people in the country. While microfinance attempts to bring rural people within the organized credit delivery fold, micro insurance attempts to provide insurance and social security measures for those not part of the organized set up.

Micro insurance is a mechanism to protect low income people against risk, such as accident, illness, and natural disasters, in exchange for insurance premium payments tailored to their needs, income and level of risk. The micro insurance sector is a fast-growing industry with a potentially untapped market of over 2 billion people worldwide. The term "micro insurance" typically refers to insurance services offered primarily to clients with low income and limited access to mainstream insurance services and other means of effectively coping with risk. In the light of decreasing motivation to introduce micro insurance products, it is time to redefine the concept. Even as rural banking obligations for new bank hopefuls are in the limelight, it may be time to take a look at similar obligations for insurance companies and how they are being implemented. These products are distributed with the help of NGOs, self help groups and micro finance institutions. This approach has helped the insurers cut distribution cost by 15%.

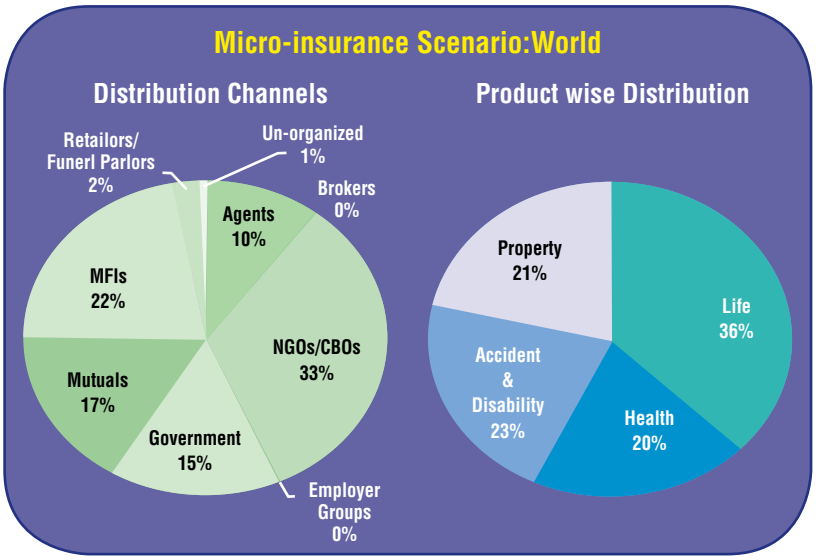
Micro-insurance is gaining some traction in rural India though it is slow as compared to the growth of the insurance market in urban India. Micro insurance is expected to get hot in the coming days as more and more private players are slated to enter the rural market with their products. As the urban market gets competitive, private players are finding rural micro insurance attractive than ever. Only 26 per cent of rural people as compared to 60 per cent in urban India have life insurance cover. Add to this, low distribution cost and rising rural income makes a rural foray an attractive proposition. Keeping in mind concerns that a competitive, open environment could lead to the neglect of the rural and weaker sections of India, the Insurance Regulatory and Development Authority of India (IRDAI) passed the IRDAI (Obligation of Insurers to Rural or Social Sectors) Regulations Act in 2002. After that, every insurance company was required to engage with the rural and social sectors by complying with mandatory obligations.

There are today 29 general insurance and 24 life insurance companies in India. The IRDAI regulations set rural insurance targets for each company. These require that 7 per cent of all life insurance business should be generated from the rural social sector in the first financial year, and this should increase annually to

reach 18 per cent by the sixth financial year. For general insurance, 2 per cent of insured premium in the first financial year should be from rural social business, increasing annually to 5 per cent in the sixth year.

(iv) exploring exciting distribution channels such as internet kiosks;

(v) Introducing products such as weather-based insurance, rainfall-index insurance.



The definition of micro insurance in India is primarily a product-based, monetary one. The regulation sets the boundaries of the cost and coverage of the product and provides clarity about distribution mechanisms. India is one of the first countries to adopt micro insurance formally through the Micro insurance Regulations Act in 2005. The regulation sets boundaries for the cost and coverage of the product and provides clarity about distribution mechanisms. Insurers in the private sector, while meeting the obligations, have brought in significant innovations in products and processes to serve the poor, such as:

(i) co-payment models;

(ii) increasing client value with products such as health screening, tele-medicine, no claim discounts;

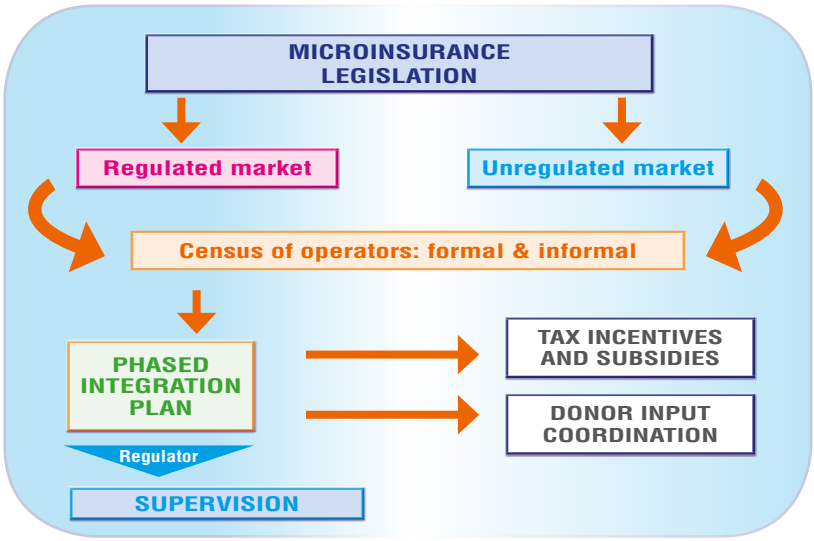
(iii) mobile enrolments;

More precisely, micro insurance is a means of protecting low income people against specific risks in exchange for a regular payment of premiums whose amount is proportional to the likelihood and cost of the relevant risk. The principal distinction from traditional insurance is in the targeting of low income people, which leads to distinct characteristics and objectives, including addressing the particular risks of low income people, affordability and inclusiveness, simplicity and clarity in documentation, accessible processes, and building trust among target clients. Micro insurance is a highly diversified sector, in terms of:

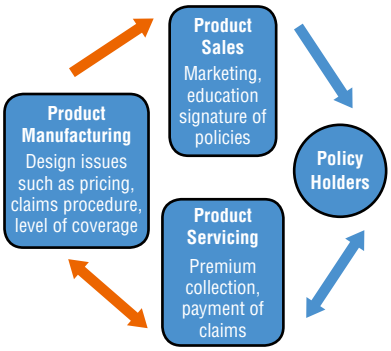
- **Stakeholders:** Micro insurance is developed and offered by commercial insurers, mutual funds, microfinance institutions, NGOs, governments or semi-public bodies. Micro insurance ventures are often joint efforts among several of these stakeholders, who can play roles ranging from market research and product design to selling, delivering, and servicing claims.

- **Products:** Micro insurance products can cover any insurable risk, including death, illness, accident, property damage, unemployment, crop failure, or loss of livestock.

- **Portfolio Size:** Micro insurance can operate at any scale; a micro insurer may cover dozens of policyholders, or millions.



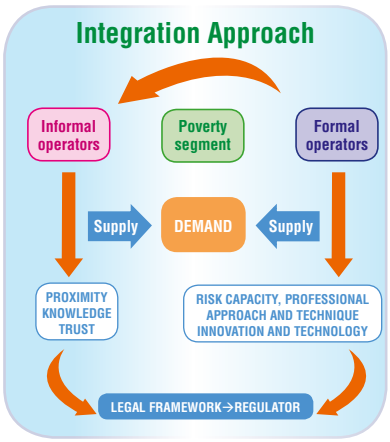
Activities Involved in Offering Insurance



By mid-century, India will be the world's most populated nation, but also home to more poor people than any other country. A crucial asset in the fight against poverty could be micro insurance that covers the poor against disease, accidents and natural disasters.

2. The Role of Micro Risk

Micro insurance provides poor and low-income households with the means to protect themselves against the effects of risk. The role of micro insurance must be viewed alongside government provision of basic health services, fire fighting services, employment and education, etc., all of which go towards alleviating poverty. There are many Micro insurance schemes around the world today, but they still only meet a fraction of the overall need. Although Micro insurance schemes have become self-sustaining, many still rely on receiving essential support in the form of grants and technical assistance. For Micro insurance to become successful – for both policy-holders and insurers – several elements are important. These include simple and affordable insurance products reaching large numbers of people; stream-lined administration, premium payment; simplified claims; management; and prompt delivery of benefits. All are important to provide "real value" to the target audience.



Micro insurance can also be a tool to extend social protection in the context of providing security to populations in developing countries and contributing to poverty alleviation. Overall, strategies and mechanisms should ensure that micro insurance is not approached in isolation, thereby maximizing impact.

Indian insurers have not readily embraced the concept of micro insurance. However, a study by **MicroSave** in 2012 shows that there were 23 registered micro insurance products filed by 16 companies compared to 64 products sold as Rural Social Obligations, but not registered as micro insurance. It was also seen that the number of micro insurance products registered with IRDAI over the last five years also shows a decline from 11 in 2007-08 to just one in 2009-10. No products were registered from 2010-11. Only 7 life insurance companies sold micro insurance products in 2010-11. Clearly, the motivation to introduce micro insurance products seems to be decreasing. This also raises the question as to how the companies are meeting their rural social targets.

Micro Insurance Regulations (Life) Product Design Guidelines

Type of Cover	Min. Amount of Cover	Min. Amount of Cover	Term of Cover Min.	Term of Cover Max.	Min. Age at Entry	Max. Age at Entry
Term Insurance with or without return of premium	₹ 5,000	₹ 50,000	5 years	15 years	18	60
Endowment Insurance	₹ 5,000	₹ 30,000	5 years	15 years	18	60
Health Insurance Contract (Individual)	₹ 5,000	₹ 30,000	1 year	7 years	Insurer's discretion	Insurer's discretion
Health Insurance Contract (Family)	₹ 10,000	₹ 30,000	1 year	7 years	Insurer's discretion	Insurer's discretion
Accident benefit as arider	₹ 10,000	₹ 50,000	5 years	15 years	18	60

Micro Insurance looks to aid low-income households by offering insurance plans tailored to their needs and provide protection to individuals. Because the coverage value is lower than a usual insurance plan, the insured people pay considerably smaller premiums.

Micro Insurance Regulations (Non-Life) Product Design Guidelines

Type of Cover	Min. Amount of Cover	Mix. Amount of Cover	Term of Cover Min.	Term of Cover Max.	Min. Age at Entry	Max. Age at Entry
Dwelling and Contracts, or livestock or tools or crop insurance against all perils	₹ 5,000 per asset/ cover	₹ 30,000 per asset/ cover	1 year	1 year	NA	NA
Health Insurance Contract (Ind.)	₹ 5,000	₹ 30,000	1 year	1 year	Insurer's discretion	
Health Insurance Contract (family) (Option to avail limit for Individual/Float on Family	₹ 10,000	₹ 30,000	1 year	1 year	Insurer's discretion	
Personal Accident (per life earning member of family)	₹ 10,000	₹ 50,000	1 year	1 year	5	70

A study by the C. K. Prahalad Centre for Emerging India (LIBA) showed that insurers were inconsistent in using the term micro insurance and reporting its performance. For instance, firms such as ICICI Lombard, HDFC Ergo and Bharti Axa described their products for the poor simply as 'rural products'. Others such as Bajaj Allianz and Birla Sun Life referred to them as micro insurance. This suggests that the terms are chosen arbitrarily, rather than backed by a sound understanding of what it includes or excludes.

Micro Insurance Regulations

Comparison of Remuneration to MI Agents		
Parameter	**Micro-insurance**	**Tradi-tional**
Single Premium	10%	2%
Regular Premium		
First Year	20%	40%
Second Year	20%	7.50%
Third Year	20%	7.50%
Subsequent Years	20%	5%

3. New IRDAI Micro Insurance Regulations

On 13th March 2015, the Insurance Regulatory and Development Authority (IRDAI) India introduced the revised Micro insurance Regulation (2015) which supersedes the existing regulations introduced in 2005. Withdrawal of all existing micro insurance products which do not meet the stipulations of the new regulation was done. The new regulation makes a number of important amendments including to the guidance on product development, adjusting the risk coverage levels, permitting more entities to distribute micro insurance products and the training of MI agents and their specified personnel. It also introduces a change in the existing compliance norms for insurance companies which had been established under the Rural and Social Sector Obligations (2002). Of particular note is the introduction of a new product category called micro variable life, a hybrid product category which offers the customer the benefit of systematic contribution with term insurance coverage.

Indian Micro Insurance : Regulations

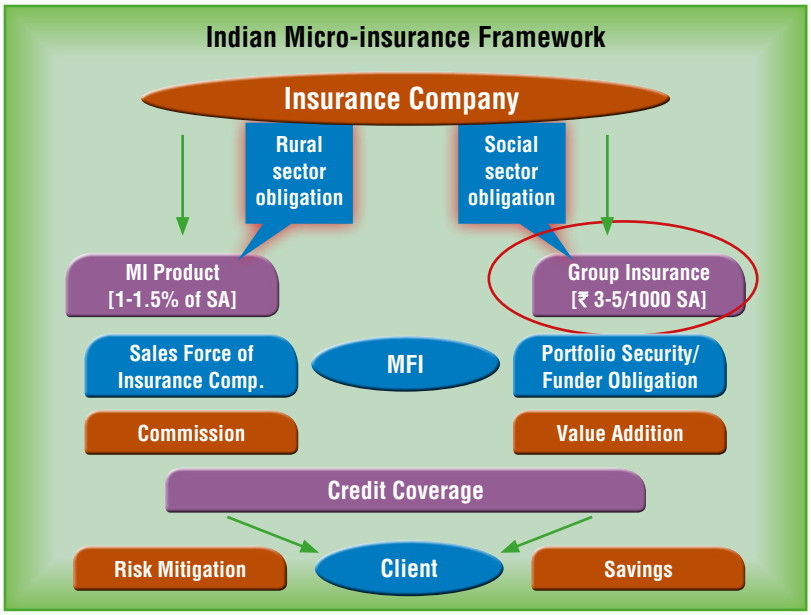
Rural Sector Obligation			
Life Insurance		General Insurance	
Year of Operation	% of total NOP	Year of Operation	% of total NOP
1st	5	1st	2
2nd	7	2nd	3
3rd	10	3rd - 5th	5
4th	12		
5th	15		
6th - 10th year	18-20	6th - 10th year	7-10

With a huge population and large untapped market, insurance happens to be a big opportunity in India. The IRDAI allowed the existing micro insurance products to continue till March 31, 2016. As per Insurance Regulatory and Development Authority of India (Micro Insurance) Regulations, 2015, it was mandated to withdraw all existing micro insurance products that were not in compliance to these regulations.

Micro Insurance Regulation

Enabling Features	Critiques
• Higher commission for prolong association ➢ 20% in life, 15% in general • Greater responsibility for MI agents • Qualify for both rural and social sector numbers • Benign negligence towards community based micro-insurance schemes	• Definition of MI agent ➢ Issues with NBFCs/Sec.25 ◆ 80% of clients belong to them ◆ Capacity building cost less • Commission capping ➢ Lapsation rate is high ➢ NBFCs associate for long term ➢ Companies prefer not to renew • Showing premium in books • Single Life & General insurer • Bias towards partner-agent model

It was observed that since the date of notification, only a few products were filed by the insurance companies. Hence to ensure availability of the micro insurance products adequately in the interest of the segment of low income group, the Authority extended the date for continuance of existing MI (micro insurance) products till March 31, 2016. The new product category, **Micro**



Variable Life Insurance Products, is a hybrid insurance solution comprising systematic contributions with term insurance cover. This product has a lock-in period of five years during which policy surrenders are not allowed, but partial withdrawals permitted. Lastly the new regulation no longer recognises policies sourced as part of social security schemes as micro insurance, and prohibits insurance companies from including them as part of their reporting on their rural and social sector mandatory targets.

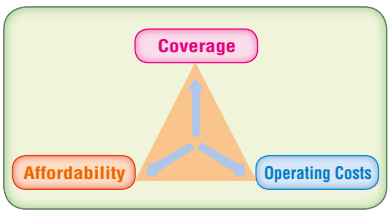
In terms of **risk coverage** levels, the new regulation sees an increase in the maximum limits across previously specified risk coverage levels. The earlier limits ranged between INR 5,000 and INR 50,000 depending on the type of product. The new limits are set as follows: for life INR 200,000, for non-life INR 100,000 and for group health INR 250,000. This will enable insurers target consumers across the lower middle income segment, which remains presently largely uninsured on account of the unattractive (low) coverage limits and poor access.

At this juncture the introduction of micro insurance by micro financial institutions and various public and private insurance companies comes from the recognition that this can serve the interests of marginalised sections and become the effective approach of financial inclusion in India. However, still micro insurance in India faces many constraints and needs urgent and suitable policy attention.

4. Strategic Changes in Micro Insurance

The characteristic trait of micro insurance is assistance for the low income segment but incorporating the basic principles of the traditional insurance activity, such as regularly paid premiums, the uncertainty of the risks and the proportionality of the premiums to the risks and costs. Some aspects of this definition are difficult to apply in the low income segment. This difficulty impinges on the product and the activity itself, limiting implementation of the principles of the traditional insurance activity. One positive trait of micro insurance, from the cost and affordability viewpoint, is the group contracting nature of this arrangement, albeit normally on a family basis. This saves costs and introduces an across-the-board premium for everyone with the same coverage.

Striking A Balance : The Microinsurance Challenge



From the demand point of view, group contracting means that these groups have to be identified beforehand, to find out their needs and offer products meeting these needs and their priorities. Financial inclusion is now one of the most talked about agendas towards holistic development of the country. With the thrust towards financial inclusion by the government to achieve all round growth of society, micro insurance is poised to play an important role in it.

Micro insurance is essential to ensure financial support for the large chunk of rural and urban poor population in the country, especially when it comes to insuring their lives or property for a small quantum of premium. According to IRDAI micro-insurance regulations announced in 2005, micro insurance was a life or general insurance policy

with a sum assured of ₹ 50,000 or less and the average ticket size ranges between ₹ 500 and ₹ 1000. But in the modified IRDAI regulations for micro life insurance, the maximum sum assured limit has been raised to ₹ 2,00,000 and the maximum premium has been capped at ₹ 6,000. While these products offer coverage to low income households in the rural areas, it helps insurers increase penetration in the rural markets. IRDAI has also set a target for insurers to generate a certain portion of their business from the rural markets by selling micro-insurance products.

Strategic Change in Micro Insurance

Issues in Product Design
Marketing Micro Insurance
Distribution Channels
Consumer Protection
Data Collection
Micro Insurance Awareness
Work Force

There is flexibility in the regulations for insurers to offer composite covers or package products that include life and general insurance covers together.

Intermediaries

Micro- insurance business is done through the following intermediaries:

- Non-Government Organisations
- Self-Help Groups
- Micro-Finance Institutions

Micro insurance is potentially a large market in India. Micro insurance needs simple products that can be easily understood, sold and that can penetrate the lower middle class segment of the society. It is a high volume, low-margin business.

The revised Micro Insurance guidelines 2015 provides as follow:

Schedule I [See Regulation 2 (d)]

Type of Cover	Maximum Amount of Cover	Term of Cover Min.	Term of Cover Max.	Minimum Age at entry	Maximum age at entry
Dwelling and contents or livestock or tools or implements or other names assets or crop insurance–againss all perils	₹ 1,00,000 Per Asset/ Cover	1 year	1 year	N.A.	N.A.
Health Insurance Contract (Individual)	₹ 1,00,000	1 year	1 year	Product Specific	Product Specific
Health Insurance Contract (Family/Group)	₹ 2,50,000	1 year	1 year	Product Specific	Product Specific
Personal Accident (Individual/Family/Group)	₹ 1,00,000	1 year	1 year	Product Specific	Product Specific

More than 70% of the population lives in rural areas. At the same time their consumption pattern, choice and preference has changed. Technology and internet has given ample scope for rural people to adopt new ideas. Micro insurance is an avenue that has fostered growth, which has been specially designed for rural people with low premium and high coverage. Other amended provisions are shown hereunder:

Table - A

Where the policy is discontinued during the policy year	Maximum Discontinuance Charges applicable to Micro Variable Life Insurance Products
1	Lower of 20%* (AP or policy account value) subject to a maximum of ₹ 800
2	Lower of 15%* (AP or policy account value) subject to a maximum of ₹ 600
3	Lower of 10%* (AP or policy account value) subject to a maximum of ₹ 400
4	Lower of 5%* (AP or policy account value) subject to a maximum of ₹ 200
5 and onwards	Nil

Commercial, consumer and regulatory environments are combining to form a fertile breeding ground for the much-needed innovation in the Indian life insurance industry. In the past few years, there have been few unique features introduced in different products. Increasing consumer preference for convenience has also driven players to relook at the delivery model and simplify the process of buying insurance.

Table - B

Where the policy is discontinued during the policy year	Maximum Discontinuance Charges applicable to Micro Variable Life Insurance Products
1	Lower of 2%* (SP or policy account value) subject to a maximum of ₹ 800/-
2	Lower of 1.5%* (SP or policy account value) subject to a maximum of ₹ 600/-
3	Lower of 1%* (SP or policy account value) subject to a maximum of ₹ 400/-
4	Lower of 0.5%* (SP or policy account value) subject to a maximum of ₹ 200/-
5 and onwards	Nil

**AP- Annualised Premium*
**SP-Single Premium*

We are witnessing a growing trend among insurers who are adopting alternate channels of distribution such as bancassurance partnerships, corporate agents and brokers that will fuel business growth. An innovative idea of distribution is the new mantra and insurers need to align their business strategy in line with changing customer requirements and preferences. It is imperative to strike the right balance between traditional and modern models to survive for a longer period of time.

VII. *Difference between Gross Yield and Net Yield for all Micro Variable Life Insurance product*

The maximum reduction in yield for micro variable life insurance policies from the policy anniversary shall be in accordance with the following Table (c).

Table - C

Number of years elapsed since inception	Maximum Reduction in Yield (Difference between Gross and Net Yield (% pa.))
5	4.80%
6	4.50%
7	4.20%
8	4.00%
9	3.80%
10	3.60%
11 and 12	3.30%
13 and 14	3.00%
15 and thereafter	2.65%

5. Managing Microinsurance Distribution

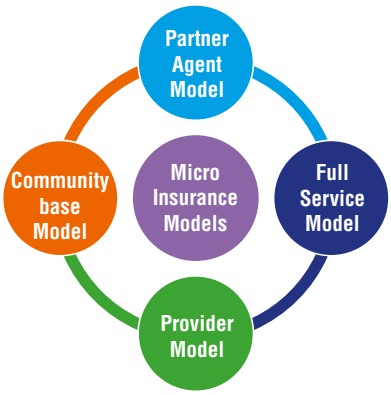
Distribution is a particularly important question for those looking to deliver insurance to low-income people. With low margins, insurers need to find low-cost channels that can reach clients in large numbers. These challenges mean that insurers need to think differently about micro insurance distribution. This training will help equip insurers with a good understanding of the wide range of distribution possibilities, and provide them with tools and knowledge needed to establish and manage a distribution strategy.

New distribution channels like business correspondents, national e-governance plan, national rural livelihood mission and co-operative banks can be looked at to improve the level of service and reach out to more people. Awareness campaigns can be run through the use of innovative mediums like posters, flip charts, jingles and plays. These will help in explaining concepts of insurance in a simple, engaging and interactive manner. Training for women in rural areas with the help of SHGs has also worked well. It's essential that all parts of an awareness toolkit should be presented in a synchronised way in vernacular languages for customer understanding.

Another concern is the absence of official documents that indicate age, health, education and other details of the insured. Partnering with local NGOs, MFIs, SHGs or other local bodies for collecting these details or reaching out to the insured has been helpful. Creating new processes for underwriting large number of policies and improving service delivery procedures will go a long way in making the micro-insurance business cost effective and both the insurer and the beneficiary of insurance will mutually benefit.

With respect to **distribution**, the new regulation enlarges the current range of institutional intermediaries to include Reserve Bank of India (RBI) regulated Non-banking Financial Companies, District Cooperative Banks, Regional Rural Banks and Urban Co-operative Banks, Primary Agricultural Cooperative Societies registered under the Cooperative Societies Act, and Business Correspondents who have

Micro Insurance Delivery Model



Example of Micro Insurance Delivery

Partner-Agent Model	Full-Service Model
• Insurers utilize MFIs' delivery mechanism to provide sales and basic services to clients • There is no risk and limited administrative burden for MFIs	• The provider is responsible for all aspects of product manufacturing, sales, servicing and claims assessment • The insurers are responsible for all insurance-related costs and losses and they retain all profits
Community-Based Model	**Provider Model**
• The policyholders own and manage the insurance program, and negotiate with external health care providers	• The service provider and the insurer are the same, i.e., hospitals or doctors offer policies to individual or groups

been appointed in accordance with the RBI Financial Inclusion Guidelines. In connection to **training**, the new regulation specifies a mandatory training period of **25-hours** for individuals employed as micro insurance agents ("agents and their specified persons"). Individuals selling non-life products to micro and small enterprises now need to undergo an additional 25 hours training. In addition, every micro insurance agent or sales person needs to undergo refresher training for half of the specified mandatory training time at the end of 3 years.

The opportunity for growth in micro insurance seems to be tremendous. A recent UNDP study revealed that 66 per cent of Indian households are "completely excluded" from any kind of financial services; they do not even have bank accounts. Insurance has a worse tale to tell. Over 90 per cent of the population is not covered by insurance and this creates a bigger opportunity to tap the rural market as majority still lives in villages. This is where the role of micro insurance becomes prominent. Micro-insurance is an insurance product targeted for the population at the bottom of the pyramid.

Based on the IRDAI recommendations, micro insurance products are distributed through regional rural banks, MFIs, cooperative banks, NGOs, self-help groups and dairy federations in rural areas. India has the most dynamic Micro insurance sector in the world, owing to its population size. 70% of India's population lives in rural areas. This section of the population is often poor, with low literacy rates. Major concerns are poor health and limited access to good healthcare services. Liberalization of the economy has helped the insurance sector to create new opportunities for insurance to reach the vast majority of the poor, including those working in the informal sector.

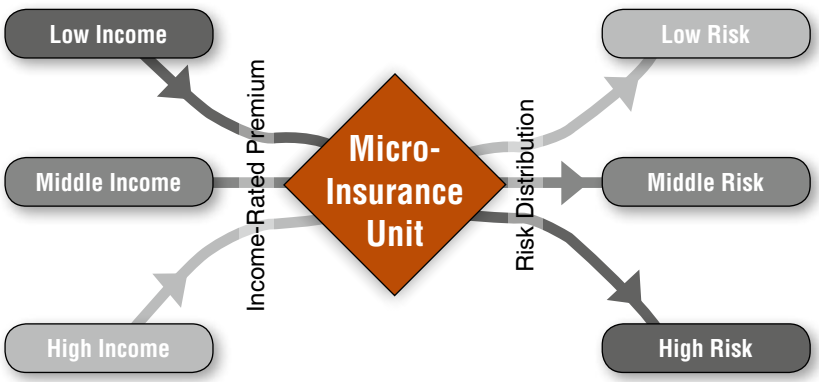
Micro insurance in India has valuable lessons for the rest of the world, particularly in the regulation of the industry. Also to encourage insurance penetration in rural areas, IRDAI has advised to use the common service centres (CSC) network last year. A network of over 1,37,000 CSCs is available to market micro insurance products of all life and non-life insurers. With a very low insurance penetration, India provides immense opportunities in the years to come. The challenge is to continuously look at simpler, easier products and effective modes of distribution. Insurers as an industry play a vital role in helping people achieve their goals and be financially independent. The opportunity is to look at needs and gaps of different target segments and have customised solutions for these groups. Players who will understand this and experiment with new solutions without fear of failure are the ones who will gain the most.

6. Feasiblity from the Social & Business Point of View?

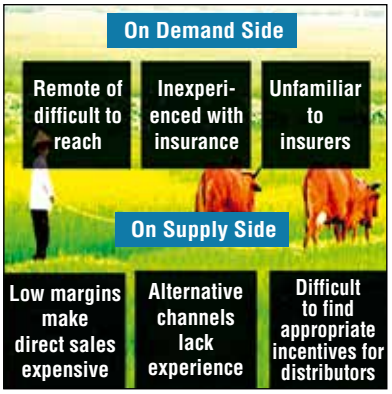
Insurers are constantly working on ways to reduce the operational costs for micro insurance products on a regular basis. Given the small amount of premium and higher lapsation due to erratic income, insurers end up spending more on providing insurance cover. Absence of financial literacy and awareness of the benefits of insurance make it difficult to convince people on how insurance is essential for assured financial security in the event of a death or major loss. Innovative processes are chalked out to address these issues. This question in turn begs another two:

1. What is at stake when we are deciding whether or not to move into micro insurance?
2. Is it worthwhile from the social and business point of view to hurdle the micro insurance barriers?

The answer will come from an analysis which cost out the social commitment of improving the situation of low income segments and making them less vulnerable while also showing the business potential of this market and strategic approaches for breaking into the market in the short and medium term. The idea behind the proposed micro-insurance model is to collect contributions on an income-measured basis and regardless of individual risks, and then, through the risk-pooling mechanism of the micro-insurance scheme, distribute resources over the individuals based on their needs and their actual risks. The wealth pyramid below gives some idea of the market potential.



Analysing the market structure shown in the above graph, and without taking into account the lowest extreme-poverty stratum dependent on state aid, many insurers are going to focus on the potential market with minimum payment capacities, a *sine qua non* of self-sustainability. The indigent or extreme-poverty stratum would fit only in social or mixed micro insurance schemes focussing mainly on healthcare, which will be dealt with in their own right. The regulations prescribe a framework within which insurers can offer affordable micro insurance products to a targeted group of rural and urban insurable population. Due to the non-availability of distributors, insurers also do not have the economic viability to set up branches in rural areas to sell products. From a distributor's perspective, as these products have a term of five years and above, it is difficult to sell it to small households. Customers do not want to buy products for the long term, since there is no guarantee of their income for such a long duration.



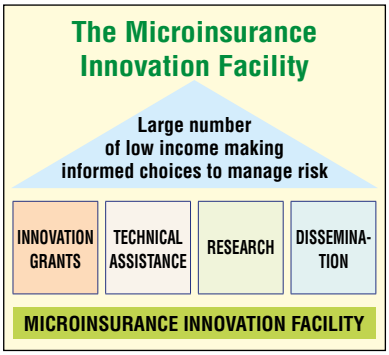
According to regulations, district cooperative banks, non-governmental organisations (NGOs), microfinance institutions (MFIs), regional rural and urban co-operative banks, primary agricultural cooperative societies, companies appointed as banking correspondents and individual owners of kirana shops, medical shops, petrol pumps and public call offices in rural areas are acting as micro-insurance agents. As the business focus and model vary for NGOs and MFIs, insurance is not a core area for them. While they help insurer in the initial phases, they are not ready to take on distributing insurance as they believe it is not an area of business for them.

Despite its rapid growth, India remains a poor country. Only one in ten Indian workers are formally employed, according to the OECD. The vast majority of Indians work informally, pay no taxes, and enjoy no social protection whatsoever. They must look after themselves, because no one else will. Some are rich enough to buy mainstream insurance, but more than 850 million Indians earn less than 2 dollars a day, according to the International Labour Organization (ILO)—not enough to afford traditional coverage. Micro insurance, however, can cost only a few Euros per year and could help those with a low income to overcome the financial shocks that come along with natural disasters, accidents, or disease. Among the major benefits of applying micro-insurance as a building block for a national healthcare system is the way it deals with specific communities' needs and expectations. Since it is specifically designed and managed by a community, a micro-insurance model can be created in a way that accounts for the differences in choices of the preferred healthcare system detailed in the study findings.

Micro Insurance vs Traditional Insurance

Trait	Traditional Insurance	Micro Insurance	Micro Insurance MBA Practices
Target Market	Middle-to-high-income sector	Low-income and informal sector	Generally clients of MFIs
Delivery Channels	Sold through individual licensed agents or brokers	Sold through licensed non-traditional agents such as cooperatives, NGOS and rural banks	MFIs and other organised groups
Underwriting Requirements	Complex (may include medical exams, etc.)	Simple, easy to understand and minimal	Compulsory membership
Premium	No limitations on premium payment	Less than P1 per day but not more than 5% of the daily minimum wage rate in metro manila	PHP 12 to 30 contribution per week

The most noticeable defect in the implementation of a micro-insurance scheme on a large, national scale is the fact that the funding of these schemes does come with a price, which is the limited risk-pooling between a small number of individuals and the presence of cross-subsidies only within the members of the micro-insurance unit.



7. The Microinsurance Supply Chain

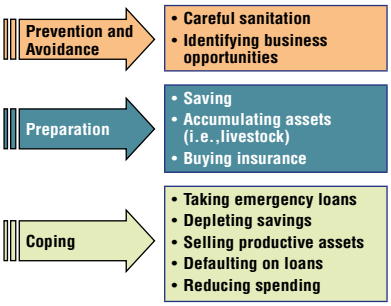
The Indian government has realized the benefits of low-premium coverage. Insurance companies now operating in India have to do a certain amount of business in rural areas or face hefty fees. Given the low income of most Indian farmers this almost always means underwriting micro insurance policies. Micro insurance growth is concentrated in South India, owing mainly to the growth of microfinance in the area. The poorer and more conflict-prone north is slowly catching up. Certain special features are as follow:

The Insurers: The most important task of the insurer is to carry risk and pay the claims. Since they carry the risk insurers have a final say in setting the price and ensuring that the product can control some of the risk. There are regulated and unregulated insurers.

The Reinsurer: Insurers hold reserves allowing them to pay for normal claims but would be insufficient for claims if all policy holders claimed simultaneously. Reinsurers are special type of insurers who "insure the insurers" against excessive losses. These players normally do not play a large role in micro insurance.

The Delivery Channel: this is the organisation or individual selling and servicing the insurance policy, the most common being the insurance agent, however they are not very common in micro insurance. The reason being that

How Do Poor People Protect Themselves from Risk?



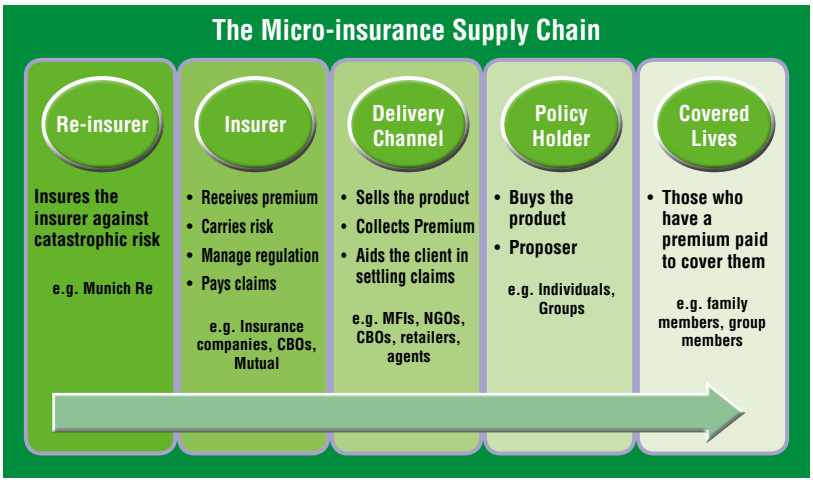
insurance agents are typically paid via the commission they earn on the policy they are selling. However, in micro insurance with its tiny premiums, this is often seen as not worth it. Evidently with regard to the delivery channel, one should also keep in mind technology and how mobile phones or other devices could support the sale of micro insurance in the future.

Policy Holders: The policy holder pays the premium and makes the claims. A policy holder can be an individual or a group. In micro insurance individual policy holders are less common than groups, the reason being that it is much cheaper to sell small value policies to all group members than to sell to individuals (e.g., trade unions often buy "in bulk" for their members).

Covered Lives/Property: Covered lives are the people whose lives are insured. An individual can take out a life insurance policy on all members in his/her household. This is different from beneficiaries who are simply named as recipient of the claim settlement in case of loss.

To ensure that more banking correspondents and distributors sell micro-insurance products, the sum assured for micro-insurance products as been increased to ₹ 1 lakh. The IRDAI has allowed regional rural banks (RRBs), micro-finance institutions, district cooperative banks, Non-Governmental Organizations (NGOs), self-help groups, urban cooperative banks, banking correspondents and individual owners of kirana stores, public Call Offices (PCOs), petrol pumps and fair-price shops in rural areas will be allowed to sell these products. With a higher ticket size, distributors can earn higher commissions from the products that they sell.

The Micro-insurance Supply Chain



8. Micro Insurnce Agents

A number of micro insurance schemes are state-led. Many others are partnerships between private insurance companies and microfinance institutions (MFIs). In such a partnership, the MFI assumes the role of an agent and distributes the product of the insurance company to its clients. This helps the insurance company to reach difficult markets cheaply, an important precondition for low premiums. The insurance company also benefits from the trust relationship the local microfinance institution has established with the target

populations. Trust of the prospective client to the insurer is one of the main hindrances, because you pay now but your benefit is in the future. For distribution, the classic partner-agent model is becoming popular, as it is preferred by suppliers and provides an economic incentive to Indian agents. However, large numbers of informal models run by NGOs, microfinance institutions, co-operatives, and credit unions exist, as well as products offered by central and state governments. Micro insurance, which aims to extend insurance coverage to low-income households in rural areas, has failed to enthuse distributors due to its comparatively small size and lower commissions.

Micro agents do not want to distribute these insurance products since there is a very low commission structure. At 15 per cent commission, there is no incentive to sell. According to the Insurance Regulatory and Development Authority's (IRDAI) micro-insurance regulations, the commission is capped at 15 per cent of the premium in the non-life segment and 20 per cent in the life segment. Data from insurance company disclosures show a majority of companies do not have micro agents. Above the mandatory 25 per cent of new business in life insurance in rural areas and seven per cent of total business in general insurance, companies are not interested in selling more micro policies.

Micro Insurance Agents of Life Insurers - 2015-16

Insurer	As on 1st April, 2015	Addi-tions	Dele-tions	As on 31st March, 2016
Private Total	3,382	6,392	1,307	8,467
LIC	19,379	997	1,802	18,574
Industry Total	22,761	7,389	3,109	27,041

9. Micro Insurance Product Specification

In order to facilitate penetration of insurance to the lower income segments of population, IRDAI had formulated the micro insurance regulations. Micro Insurance Regulations provide a platform to distribute insurance products, which are affordable to the rural and urban poor and to enable micro insurance to be an integral part of the country's wider insurance system.

While IRDAI has allowed a tie-up of life and non-life insurers to offer micro-insurance products, there has been no significant progress in that area. The main thrust of micro insurance regulations is protection of the low income people with affordable insurance products to help cope with and recover from common risks with standardized popular insurance products adhering to certain levels of cover, premium and benefit standards.

List of Micro Insurance Products of Life Insurers
As at 31.03.2016

Insurer	Name of the Product	
	Individual Category	Group Category
AVIVA LIFE	Aviva Nayi Grameen Suraksha	–
BAJAJ ALLIANZ LIFE	Bajaj Allianz Life Bima Dhan Surakaha Yojana	–
	Bajaj Allianz Life Bima Dhan Suraksha Yojana	–
	Bajaj Allianz Life Bima Sanchay Yojana	–
BHARTI AXA LIFE	–	Bharti AXA Life Jan Suraksha
BIRLA SUNLIFE	BSLI Bima Suraksha Super	–
	BSLI Grameen Jeevan Raksha	–
CANARA HSBC OBC LIFE	–	Canara HSBC Oriental Bank Of Commerce Life Insurance Sampoorna Kavach Plan
DHFL PRAMERICA LIFE	–	DHFL Pramerica Sarv Suraksha
EDELWEISS TOKIO LIFE	Edelweiss Tokio Life Raksha Kavach	–
	Edelweiss Tokio Life Dhan Nivesh Bima Yojana	–
HDFC STANDARD LIFE	HDFC SL Sarv Grameen Bachat Yojana	–
ICICI PRUDENTIAL LIFE	ICICI Pru Anmol Bachat	–
	ICICI Pru Sarva Jana Suraksha	–
IDBI FEDERAL LIFE	Termsurance Sampoorn Suraksha Micro-insurance Plan	IDBI Federal Group Microsurance Plan
KOTAK MAHINDRA LIFE	Sampoorn Bima Micro-Insurance Plan	–
PNB MET LIFE	MetLife Grameen Ashray	–
SAHARA LIFE	Sahara Surakshit Pariwar Jeeven Bima	–
SBI LIFE	SBI Life Grameen Bima	SBI Life Grameen Super Suraksha
		SBI Life Grameen Shakti
SHRIRAM LIFE	–	Shri Sahay SP
TATA AIA LIFE	Tota AIA Life Insurance Navkalyan Yojana	–
	Tata AIA Life Insurance Saath Saath	–
LIC OF INDIA	New Jeevan Mangal Bhagya Lakshmi	–

These regulations allow Non Government Organizations (NGOs) and Self Help Groups (SHGs) to act as agents to insurance companies in marketing the micro insurance products and also allow both life and non-life insurers to promote combi-micro insurance products (combination of different lines of business). Following are the micro life insurance products: In order to improve persistency in this segment, IRDAI has proposed to link the renewal commissions in micro-insurance in life segment where agents with higher persistency would get more commissions. It would be more effective to have a single policy, with options for customisation, which covers all basic insurance needs.

With the notification of the IRDAI (Micro-insurance) Regulations 2005, by the Authority, there has been a steady growth in the design of products catering to the needs of the poor. The flexibilities provided in the Regulations allow the insurers to offer composite covers or package products. Insurance companies are now offering already approved general insurance products as micro-insurance products with the approval of the Authority, if the sum assured for the product is within the range prescribed for micro-insurance.

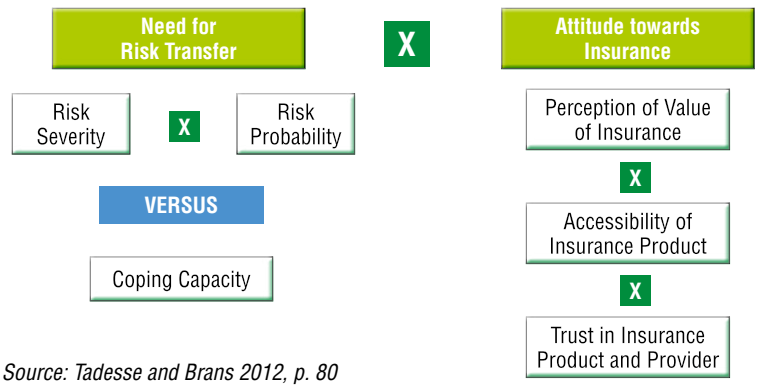
Micro-insurance involves the provision of wide-ranging insurance services to low income populations previously unable to hedge against life's uncertainties. The micro-insurance portfolio has made steady progress. More life insurers have commenced their micro-insurance operations and many new products are being introduced every year. The distribution infrastructure has also been considerably strengthened and the new business has shown a decent growth, though the volumes are still small. Micro-insurance business was procured largely under the group portfolio. Life Insurance Corporation of India (LIC) contributed the most both in terms of policies sold and number of micro-insurance agents.

10. Significant Potential in Micro-insurance Space

There is a significant potential in the micro insurance space and insurers are committed to align with the government's vision of a financially inclusive country. Insurers leverage their multi-channel distribution network and learning from our past successes while foraying into new product categories, drive penetration for our micro insurance offerings in India. By partnering with micro finance institutions, they tap the financially underinsured sections across India and cooperatives that form a large part of the unorganised sector. With growth in micro credit in India they believe that the demand for these products will improve as an efficient tool to manage financial risk.

The Authority undertook the review of the Micro Insurance Regulations, 2005 comprehensively and notified the Amended Regulations on 13th March 2015 wherein it has permitted several more entities like District Co-operative Banks, Regional Rural Banks including Business Correspondents of Scheduled Commercial Banks to be appointed as Micro Insurance agents facilitating better penetration of the Micro Insurance business.

Demand for Micro-insurance = Need x Attitude



Source: Tadesse and Brans 2012, p. 80

Trends Derived from MI Regulation

- All companies have MI product (24 MI products)
- Composite Insurance absent in formal platform
  - Companies wait for better opportunity (regulatory risk)
  - Negotiation cost do not suffice benefit (wariness)
- NBFCs not forthcoming to become MIA
- Just in target approach by companies (Growth stagnant)
- Apprehension of IRDAI for brokering in MI space
- Greater responsibility for MIA
- Community health insurance increasing (benign neglect)
- Concentration in south India

Recent Trends in Micro-insurance

- MI through Bancassurance
- Profit sharing & shared responsibility
- Focus on savings linked products (micro-pension)
- Service and technology focus
  - Competition parameter
- Increasing awareness of BoP risks by actuaries
  - Re-negotiation of price
- Spouse cover for diversifying risks
- Community health insurers tie up with re-insurers

Life Insurance Sector

While the individual new business premium under the micro insurance segment for the year 2015-16 stood at 35.94 Crore under 9.15 lakh new policies, the group business premium amounted to 302.43 crore covering 2.93 crore lives. LIC contributed to a significant component of the business procured in this portfolio by garnering 19.54 crores of individual new business premium under 4.5 lakh policies and 254.26 crore of group premium covering 2.26 Crore lives.

New Business Under Micro-insurance Portfolio for 2015-16

(Premium in ₹ lakh)

Insurer	Individual		Group		
	Policies	Premium	Schemes	Premium	Lives Covered
PrivateTotal	458655	1217.95	153	4816.67	6650805
LIC	452291	1953.78	4844	25426.39	22603919
Industry Total	**910946**	**3171.73**	**4997**	**30243.06**	**29254724**

Note: New business premium includes first year premium and single premium.

The number of micro insurance agents at the end of March 2016stood at 27041; of which 18574 agents pertained to the LIC and the remaining represented the private sector life insurers. 27 micro insurance products of 13 life insurers were available as at 31.3.2016. Of these 27 products, 20 were Individual products and the remaining 7 were Group products.

Non-Life Sector

Micro Insurance is the insurance provided through the Micro Insurance Products which includes "general micro-insurance product. General Micro Insurance Products cover health insurance contract, any contract covering the belongings, such as, hut, livestock or tools or instruments or any personal accident contract, either on individual or group basis with a Maximum Amount of Cover as Rupees one lakh and minimum and maximum term cover of one year. The Authority in order to propagate micro insurance in various segments has permitted more entities or individuals to be appointed as Micro Insurance Agents which include Non-Government Organisations (NGO), Self-Help Groups (SHG), Micro-Finance Institution(MFI), RBI regulated NBFCMFIs, District Cooperative Banks, Regional Rural Banks, Urban Co-operative banks, Business correspondents, Primary Agricultural Cooperative Societies and Other Cooperative Societies.

There are around fifty two products offered by all registered non-life insurance companies targeting the low income segment of the population e.g., Cattle Micro Insurance, Kisan Agriculture Pumps Micro Insurance Policy, Janata Personal Accident Sukshma Bima Policy, Silkworm Sukshma Bima Policy, Sheep & Goat Micro Insurance Policy, Sampoorna Griha Suraksha Policy, etc. Further, General Insurance Policies issued to Micro, Small and Medium Enterprises as classified in MSMED Act, 2006 under various lines of General Insurance business will also qualify as general micro insurance business up to ₹ 10,000 premium p.a. per MSM enterprise.

Micro Insurance being a low price-high volume business, its success and sustainability depends mainly on keeping the transactions costs down. Sections 32B and 32C of the Insurance Act, 1938 and IRDAI (Obligations of insurers to rural and social sectors) 2015, stipulate obligations to insurers in respect of rural and social sector, which have also contributed a lot in the development and promotion of micro insurance products in India.

Micro-insurance is the protection of low income households against specific perils in exchange for premium payments proportionate to the likelihood and cost of the risk involved. It is specifically designed for the protection of low income people with affordable insurance products to help them cope with and recover from common risk. A key strategy for enhancing economic development and alleviating poverty is to make financial systems more inclusive, for example by improving access to savings and credit services for up and under-served markets. In part, Poverty stems from the fact that low-income households and markets do not have the same opportunities to finance investments accumulate capital or protect assets (including human assets). The poorest segments do not always benefit from the subsidy, while people who can afford insurance often find ways to access these benefits.

In general, governments have made little effort to shift the burden of risk-pooling to market-led schemes; and the private sector (commercial insurers) seems to have little incentive to seek out this market segment. In principle, micro-insurance works like any typical insurance business. But there are several things that differentiate it from normal insurance. First, it is group insurance that can cover thousands of customers under one contract. Second, micro-insurance requires an intermediary between the customer and the insurance company. Preferably, this intermediary is a non-governmental organization (NGO) or microfinance institution, for example a rural bank that can handle the whole distribution and most of the administration process. The few differences between traditional insurance and micro-insurance are as follows:

India is leading the way in terms of micro insurance outreach. With 111.1 million people covered, India is home to 65.2% of the people covered in Asia and Oceania. The Indian micro insurance sector also generates 66% of the premiums on the continent. Due to its massive market size, India contributes to 72% of the growth in coverage and 80% of growth in premiums in the region. But the discrepancy between coverage and absolute number of policy-holders: Indian micro insurance sector has so far been able to cover only 9% of the overall population and 14.7 % of the potential micro insurance market size in the country. In comparison, the micro insurance markets in the Philippines and in Thailand are found to be more vibrant with a coverage ratio of 20.6% and 13.9% respectively.

11. Settlement of Claims on Micro Insurance Products

India is one of the few developing countries in the world that has a special micro insurance act that regulates the suppliers through its special agency for insurance regulation – the Insurance Regulatory and Development Authority. Under the Micro insurance Regulations, insurance companies are obliged

Factor	Traditional Insurance	Micro-insurance
Clients	• Low risk environment. • Established insurance culture	• High risk exposure/ high vulnerability, • Weak insurance culture
Distribution model	• Sold by licensed intermediaries or by insurance companies directly to wealthy clients or companies that understand insurance	• Sold by non-traditional intermediaries to clients with little experience of insurance
Policies	• Complex policy documents with many exclusions	• Simple language • Few, if any; exclusion • Group policies
Premium calculation	• Good statistical data • Pricing based on Individual risk	• Little historical data, • Group pricing • Very price sensitive market
Premium collection	• Monthly/quarterly/semi or annually collection	• Frequent or irregular payment adapted to volatile cash flow of clients • Often linked with other transaction (e.g. loan repayment
Control of insurance risk (adverse selection, moral hazards, frauds)	• Limited eligibility, • Significant documentation required • Screening such as medical test is required	• Broad eligibility • Limited but effective control • Insurance risk included in premium rather than exclusion • Linked to other service (like credit)
Claims handling	• Complicated process • Extensive verification documentation	• Simple and fast procedure of small firms. • Efficient fraud control

to conduct a certain percentage of their business in rural areas or with marginalized groups. Because of these obligations and the prospect of a very large market, many micro insurance innovations stem from India. The settlement on life policies is as follows:

During the same period, non-life insurers underwrote a gross direct premium of ₹ 8,196 crore in the rural sector, which is 12.69 per cent of the gross direct premium underwritten (₹ 64,583 crore). Creating new processes for underwriting large number of policies and improving service delivery procedures will go a long way in making the micro-insurance business cost effective and both the insurer and the beneficiary will mutually benefit. Insuring the disadvantaged and rural poor is riskier than insuring urban and middle-class clients.

> India is one of the few developing countries in the world that has a special micro insurance act that regulates the suppliers through its special agency for insurance regulation – the Insurance Regulatory and Development Authority.

Individual Death Claims Under Micro-insurance Portfolio – 2015-16

(Benefit Amount in ₹ Lakhs)

Life Insurer	Total Claims		Claims Paid		Claims Repudiated/ Rejected		Claims pending at end of year	
	No. of Policies	Benefit Amount	No. of Policies	Benefit Amount	No. of Policies	Benefit Amount	No. of Policies	Benefit Amount
Private Total	4490	607.82	4427 98.60%	483.33 79.52%	63 1.40%	124.60 20.50%	0	0.12 -0.02%
LIC	9749	1584.27	9632 98.80%	1563.55 98.69%	102 1.05%	15.77 1.00%	15 0.15%	4.95 0.31%
Industry Total	**14239**	**2192.09**	**14059 98.74%**	**2046.88 93.38%**	**165 1.16%**	**140.37 6.40%**	**15 0.11%**	**4.83 0.22%**

Note: *The percentages indicate the share of the respective claims to the total claims*

Life insurers sold 25.7 per cent of new policies in 2012-13 in the rural sector. Out of these 44.1 million new policies that life insurers underwrote in 2012-13, 11.3 million were in the rural sector. In the recent past, life insurance firms issued around five million individual micro-insurance products and covered nearly 14 million people.

Duration-wise Death Claims Settled in Micro-insurance Individual Category – 2015-16

(No. of Policies)

Life Insurer	Duration Since Intimation					
	Within 30 Days	31 to 90 Days	91 to 180 Days	181 Days to 1 Year	More than 1 Year	Total Claims Settled
Private Total	4155 93.86%	237 5.35%	35 0.79%	0 0.00%	0 0.00%	4427 100.00%
LIC	7127 73.99%	2505 26.01%	0 0.00%	0 0.00%	0 0.00%	9632 100.00%
Industry Total	**11282 80.25%**	**2742 19.50%**	**35 0.25%**	**0 0.00%**	**0 0.00%**	**14059 100.00%**

Note: *The percentages indicate the share of the respective claims to the total c/aims*

Group Death Claims Under Micro-insurance Portfolio – 2015-16

(Benefit Amount in ₹ lakh)

Life Insurer	Total Claims		Claims Paid		Claims Repudiated/ Rejected		Claims Written Back		Claims Pending at end of year	
	No of Lives	Benefit Amount	No of Lives	Benefit Amount	No of Lives	Benefit Amount	No of Lives	Benefit Amount	No of Lives	Benefit Amount
Private Total	14479	3305.00	14429 99.65%	3290.91 99.57%	43 0.30%	11.69 0.35%	0	0.00	7 0.05%	2.40 0.07%
LIC	117854	38123.00	117827 99.98%	38111.30 99.97%	26 0.02%	11.40 0.03%	0	0.00	1 0.00%	0.30 0.00%
Industry Total	**132333**	**41428.00**	**132256 99.94%**	**41402.21 99,94%**	**69 0.05%**	**23.09 0.06%**	**0**	**0.00**	**8 0.01%**	**2.70 0.01%**

Note: *The percentages indicate the share of the respective claims to the total claims*

Needless to say, in the case of micro insurance, faster claim settlement (within a couple of days or a week after receiving all documents) and giving back the promised financial benefit is critical to build trust. And to ensure that the insurer is trustworthy, claim rejection needs to be minimised and closely followed up. In fact, insurers should encourage the low-income market to submit claims. Thus micro-insurance can slowly and steadily improve the statistics of financial inclusion and security in the rural areas.

All of the above factors pose a risk to the lives, incomes, and properties of the rural poor. Because of the increased risk, offering life and property insurance to this segment of the population requires in-depth understanding and a reimagining of the traditional approach to insurance. Indian micro insurance scenario is facing following issues:

1. Urban citizens offer insurance companies a reliable profit because their incomes and assets tend to remain stable. With the rural poor, this is not the case. With poorer segments of the population, insurance companies are faced with a dilemma called "adverse selection". Adverse selection occurs when insurance is available to a wide variety of people at the same price. People who face the greatest amount of risk are far more likely to purchase insurance than those with lower than average risk. This is detrimental to insurers, who profit when people purchase policies that they do not end up needing. In such cases, the insurance companies have no flexibility to leverage their own risks.
2. One way to avoid adverse selection is to raise premiums. However, higher premiums would make insurance too expensive for the rural poor – the very demographic the insurers wish to attract – to purchase. As a rule of thumb if the probability of loss exceeds 40% then the cost of the policy will exceed the amount of cover guaranteed. Therefore the cost of the premium cannot be directly related to risk, because the resultant high premiums would make insurance prohibitively expensive. This question of insurability of the segment under micro insurance surfaces now, making the grounding of program extremely difficult one.
3. If insurance companies expand their client base to include micro-enterprises and the rural poor, they expose themselves to greater risk. Consequently, when designing insurance policies for these segments of the population they must fix a premium that is high enough to cover their own risk, yet low enough to remain attractive to low-income clients. They must figure out how to acquire and maintain new customers without stretching their own risk.
4. Insurance should not be looked at as only a tool for risk management. Built into this is also a component of minimum assured savings built into insurance. It is time to reiterate this savings aspect also to attract newer clientele. True, insurers would have to reorganize their fund management to offer better returns on investment in insurance policies to the insured. That is the underlying consideration in any investment decision by an individual. An insurance decision is an investment decision – whatever the payback.

Duration-wise Death Claims Settled in Micro-insurance Group Category – 2015-16

(No. of Lives)

Life Insurer	Duration					
	Within 30 Days of Intimation	31 to 90 Days	91 to 180 Days	181 Days to 1 Year	More than 1 Year	Total Claims Settled
Private Total	12871 90.28%	1203 8.44%	112 0.79%	68 0.48%	3 0.02%	14257 100.00%
LIC	117818 99.99%	9 0.01%	0 0.00%	0 0.00%	0 0.00%	117827 100.00%
Industry Total	**130689 98.94%**	**1212 0.92%**	**112 0.08%**	**68 0.05%**	**3 0.00%**	**132084 100.00%**

Note: *The percentages indicate the share of the respective claims to the total claims*

12. Issues & Challenges

Micro insurance encompasses many types of coverage, including property, health and life insurance, and is often delivered to the vulnerable segments of society. Insuring the disadvantaged and rural poor is riskier than insuring urban and middle-class clients for several distinct reasons:

1. The risk of loss of income – uncertainty of the cash flows
2. Variability of the cash flow – high range of dispersion in income
3. Vulnerability of income to natural disasters, disease and market fluctuations
4. Seasonality of employment

5. The challenges faced by micro-insurance schemes may be the learning lesson for the generations to come. Product development, regulatory modification, financial literacy drive, distribution optimization for insurance products are a few steps to ensure better and deeper micro insurance penetration in rural areas for people living below poverty line. If rightly implemented micro insurance schemes could bring in sea change in the living standard of rural population living below poverty line. The customization of products could better suit to the need and requirement of individual customers and hence could favourably impact the demand for micro-insurance products. Training programs for insurance professionals especially sales agent in large number generates employment among the educated work force and also ensure deeper penetration and higher demand of insurance products in the market.

Indian Insurance Industry is facing the following challenges in the Micro Insurance Space:

- Grievance redressal mechanism
- Affordability of premium—limited disposable income
- Mobility of the targeted population
- High volatility and uncertainty of income
- Enhanced role of SHGs
- Documents required in vernacular language
- Developing insurance awareness amongst the low income band people
- Need for Innovative Micro Insurance Products

Regulatory frameworks develop quickly in Asia.

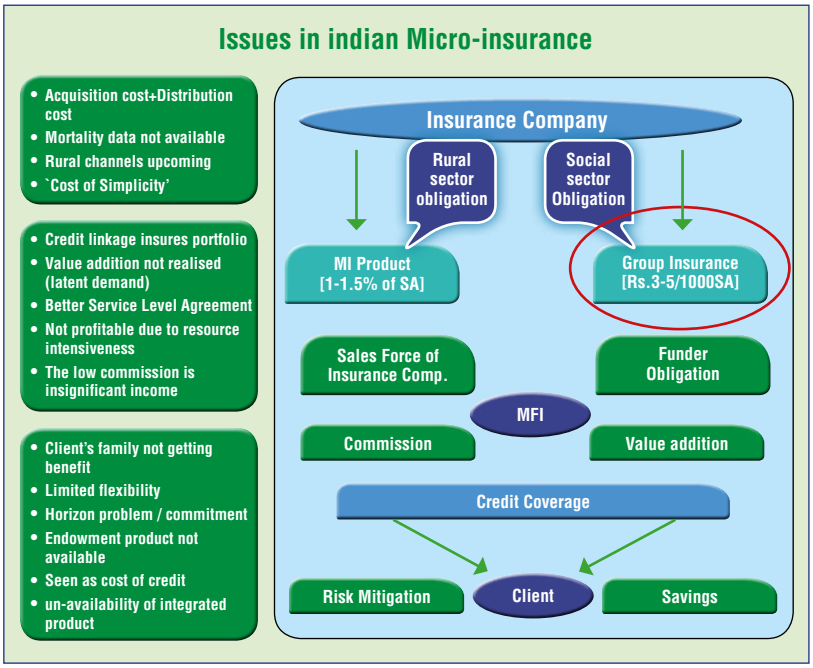
India and the Philippines have pioneered by formulating first-ever micro insurance-specific regulations for their insurance industries. Vietnam and Cambodia also have some form of micro insurance regulation in place. Bangladesh, China, Indonesia, Pakistan and Sri Lanka were also seen to formulate their first-ever micro insurance-specific regulation last year.

Long Term Insurance

- Challenges with clients
  - Migration
  - Matching with transaction patterns
  - Assurance of return
- Challenges with intermediaries
  - High cost — high involvement proposition
    - High admin cost + distribution cost
    - Standalone MI is becoming non-profitable
    - Transfer of actuarial risk and distribution cost to companies
  - Resource intensive
  - Brand / imagery risk
  - Long term tracking of clients

The Indian and Filipino regulations have attained some form of maturity, while regulators in countries such as China, Bangladesh, Pakistan and Indonesia are trying to promote their micro insurance sector by allowing newer entities into the sector, obliging commercial insurers to offer micro insurance, or by providing them additional benefits if they enter the sector. The regulatory and political environment of micro insurance is still at its inception in countries such as Mongolia and Laos, where governments run their own micro insurance pilot projects and programmes. In some other countries, such as Thailand, Malaysia and Sri Lanka, the micro insurance sector has germinated under the aegis of their general insurance and/or microfinance regulations. Although in Asia, micro insurance mainly developed from community-initiated schemes, regulated commercial insurers currently lead the sector. At present, commercial insurers have the largest outreach in

Issues in indian Micro-insurance



each and every product type. They are followed by NGOs, CBOs, mutuals and cooperatives. Most of these providers appear to be optimistic for the future and are planning for substantial growth in the years to come.

What Are Some of the Difficulties in Providing Insurance to Poor People?	
Technical Specialization	**Requires specialized capacity,** which is complicated by the lack of reliable data characteristic of low-income, informal markets.
Marketing and Sales	**Most poor people do not understand insurance or may be biased against it.**
Distribution Channels	**Requires a distribution system** that can handle small financial transactions efficiently in convenient locations, and engender trust.

Twelve Asian countries have 23 different government-run social micro insurance programmes – mainly health and agriculture – serving approximately 1.7 billion individuals. These schemes are similar to conventional micro insurance and traditional social security schemes. The difference lies in the fact that the risk is underwritten and borne by commercial insurance companies, while the government contributes towards the premium amount. These are important schemes given the fact that they often target, and deliver free insurance services to the potential market of micro insurance.

Although in Asia, micro insurance mainly developed from community-initiated schemes, regulated commercial insurers currently lead the sector. At present, commercial insurers have the largest outreach in each and every product type. They are followed by NGOs, CBOs, mutuals and cooperatives. Most of these providers appear to be optimistic for the future and are planning for substantial growth in the years to come.

MI Vs. Regular Products - Other Issues		
Parameters	**Micro Insurance**	**Regular Product**
Product Design	Simple	More Complex
Policy Wording	Simple language and few exclusions	Complex policy wording
Premium rates	Based on little historical data and price sensitive	Good quality data and better reflect individual risk characteristics
Premium Collection	Match frequent and irregular payments	All modes of payment and also sold thru' direct innovative channels
Insurance Risk	Broad eligibility, low SA and risk factored into pricing generally no underwriting	Limited eligibility, on medical and non medical basis, generally with underwriting
Claims Handling	Simple and quick procedure	More complex and lengthy procedure with requirements of various documents

Micro insurance policies for Life, Health and General Insurance can be purchased by villagers from the field agents residing in the same village, thereby generating additional revenue for the field agents, as well as bringing rural India under the gambit of Insurance. The safest way of providing insurance to the micro segment is through banks. Insurance companies can collaborate with prominent banks by selling their insurance products in local bank locations through local bank employees. Selling insurance through banks would ensure a stable client base for insurance providers because beneficiaries with bank accounts are more likely to be financially stable than beneficiaries without bank accounts. Bancassurance would be beneficial to both banks and insurance companies. Coordination with banks would allow insurance companies to expand their client base while reducing their sales staff and bringing down operating costs in the long run and banks would receive a portion of the profits from the insurance sales. Using bancassurance, insurance companies are better able to enhance their client base, sell more insurance and customize their insurance products to client needs. The road ahead requires the following:

- Need to develop Health micro insurance products
- Need for good quality data
- Standardizing underwriting procedures for MI
- Regulatory assistance

13. The Largest Single Micro Insurance Policy Provider

GSM telecom operator Telenor had said it has become the largest 'single' micro insurance policy provider in India, offering a free life insurance scheme, Telenor Suraksha, through its

partner Shriram Life. Over 17 million customers of the Norway-based telco's unit have enrolled themselves under this scheme, while around 7.8 million customers have been insured across Telenor's circles till January. Telenor claims that it has the highest number of policy holders in the country for a single micro insurance product. They are the largest 'single' micro insurance policy holder, and are bullish about the initial response. Telenor has a 50.7 million subscriber base, so they have got a fairly good opportunity to get more customers subscribed to the life insurance scheme.

By spending on regular recharges with a small incremental value, Telenor subscribers can get the benefit of a life insurance cover, which will be a hundred times the monthly recharge value and up to a maximum of ₹ 50,000. The insurance products are not widely penetrated in the market with limited easy access, even as the last mile cost is pretty high. Telenor has a very strong retail system as they are in the mass market distribution model, which helps reach customers fairly fast. Telenor, based in Gurgaon, is last reported to have settled eight claims across Uttar Pradesh East and West, Andhra Pradesh and Maharashtra with claimed amounts ranging from ₹ 10,000 to ₹ 50,000. These settlements were done within 72 hours of submission of all relevant documents.

The telco also offers free insurance to new customers for the first two months, which also helps in acquiring new customers across circles. The scheme is also helping the company increase its average revenue per unit (ARPUs), and reduce subscriber churn in the country. They are monetizing this product through recharges done by a customer month-on-month. There is one more angle to it - as the customer keeps recharging, it will help us improve ARPU and churn. Telenor has made this product available through its mass market distribution at different point of sales –around 2000 company stores, self-help service and at its call centres. While India was the first country to introduce regulation for micro insurance, the scope of this regulation is still limited. The regulator is not touching the community-based insurance movement. Another challenge faced by the sector is the lack of customer education. Many of these potential policyholders have little understanding and experience of, or trust in, insurance. On the other hand, insurers are trying desperately to get a better idea of the Indian market and its needs. There is a severe scarcity of data, which makes it difficult for many insurers to develop adequate products. At the same time, insurers have started to provide new models, which is a good initiative.

14. Case Study-Indian Examples

Micro insurance may be the product range that large insurers need to expand into new markets and to accomplish business and sustainability goals simultaneously—including innovation, access to new markets, social impact, and business growth. There are already leaders doing pioneering work but micro insurance is still a new concept in a relatively untapped market. Further product and distribution innovation, adequate market research, and scale are still challenges to expanding micro insurance. If large insurance companies can remain attuned to regional sensitivities and scale quickly, micro insurance offers a huge opportunity for insurers to penetrate new markets and build a more resilient and inclusive economy. Life insurance on the Micro insurance space shows the following features:

- Can be easily linked with other products
- Not dependent on other infrastructure
- The insured event is a clear cut fact
- Easy to price
- Resistant to moral hazard & fraud
- Claim settlement is relatively easy

Case Study : 1

Vimo SEWA functions as a cooperative. This is the organisational mode used for all of SEWA's activities. Representatives of the members carry out the various functions of the programme. These include –

i) Managing the services through local teams of Aagewans,

ii) Promoting insurances, educating members and disseminating information on insurance,

iii) Deciding on premium, new products and coverage to be offered,

iv) Deciding on claims submitted and ensuring rapid disbursement.

Self – Employed Women's Association (SEWA) is a labour union of women workers based in Ahmedabad, city of Gujarat State in India. Started in 1972 by Ela Bhatt, it is spread over six states in India – Madhya Pradesh, Uttar Pradesh, Delhi, Bihar, Kerala and Gujarat. Sewa's goal is to organise women to achieve full employment and self-reliance.
In 1992, SEWA set up its integrated insurance programme implemented by SEWA Bank, a women led microfinance institution having more than 2,00,000 depositors and ₹ one billion (equivalent to USD 20 million) worth of working capital. SEWA Bank has been providing

financial services (savings, credit and insurance) to poor women. In the year 2000, due to growing membership, SEWA set up a separate insurance unit – Vimo SEWA i.e. SEWA INSURANCE.

responsible for its further development, final decision on claims, reimbursing the claims, monitoring performance and listing new network hospitals. The TPA, Family Health Plan Limited (FHPL),

Indian Examples: VimoSEWA

- Composite product
  - Life and non-life
  - Individual policies
- Health claim
  - In house claim assessment
  - Cash paid in emergency
- Preventive health care
- TAT of 9 days
- High claim ratio in urban areas (172% in 2008)
- Sells to other NGOs

Coverage	3 months in 55 years
Sum Assured	₹ 2000-₹ 6000
Min. criteria for claim	24 hr. hospitalisation (ex. cataract/fracture
Premium	• ₹ 325-550 for comp. • ₹ 100-150 for health
Backward integration	ICICI Lombard, Reliance, Kotak Mahindra, LIC, BajajAllianz
Benefit	Life membership

Case Study : 2

Yeshasvini Trust is the actual "owner" of its insurance scheme. It is registered as a charitable trust and governed by a board of trustees. This board consists of six persons from the Department of Cooperation, who are board members by designation, the Director of the Karnataka Health Department, and five nominated board members (mainly medical professionals). The board of the trust governs the whole scheme and is

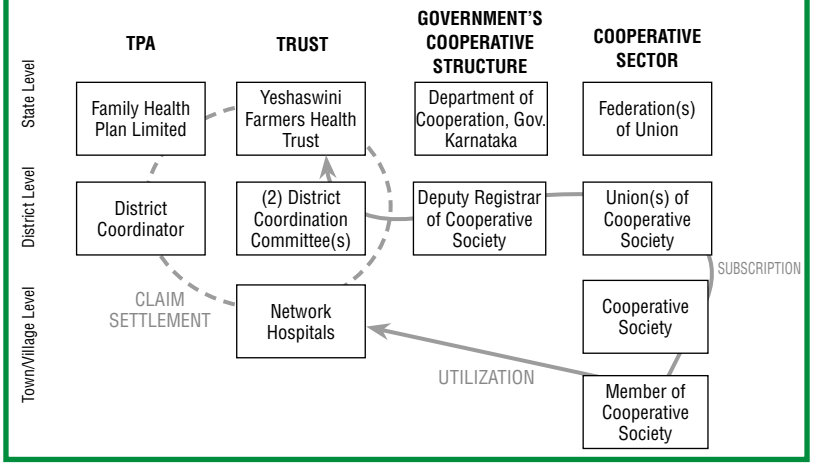
representatives of the cooperative sector (federation level) and the network hospitals may attend the meetings as well. Yeshasvini is the first insurance programme in the world to coin the term micro health insurance, and its success is because poor people trust only the government.

Case Study : 3

UTI Asset Management Company (UTI AMC) and Invest India Micro Pension Services (IIMPS) have inked a strategic partnership with the BASIX Group to deliver UTI's retirement benefit pension fund to BASIX customers. The micro-pension scheme would be investing 23 per cent in equities and later it could be extended up to a maximum of 40 per cent. The remaining would be invested in government securities. It would have zero entry load and the expense cost would be incurred by the UTI AMC itself.

IIMPS is jointly promoted by SEWA Bank, UTI AMC and leading pension and development sector experts to provide low-cost, secure and scalable mechanism to the working poor to save for their old age. Micro-pensions can play a key role in bridging India's pension coverage gap. This joint initiative by UTI AMC and IIMPS compliments larger policy and regulatory efforts in delivering sustainable retirement solutions to the working poor.

Indian Examples: Yeshaswini



Indian Examples: Micro-pension

- UTI Micro-pension
  - ₹ 50 p.m. as premium
  - Savings upto 55 years, payout from 58 years
  - Account convertible to annuities (SWP for UTI)
  - Invested in 60% debt + 40% equity instruments
- *Aam AdmiVima Yojna (GoI initiative)*
- Horizon problem + long term tracking of clients
- Cost for intermediary not met
- Match with transaction pattern
- No guarantee of return
- Demand of insurance cannot be met (COMPFED)

Case Study : 4

Max New York Life Insurance Company Ltd. (MNYL) is a joint venture between New York Life International and Max India Limited. Max New York Life started commercial operations in India in 2001. The company used a multi-channel distribution strategy. Agency distribution is the primary channel in India. The other additional distribution channels include the rural business, employed sales force involving alliance marketing, bancassurance and partnership distribution. MNYL has developed "Max Vijay", a business model designed to serve 100 million low-income Indian households by improving access to benefits of life insurance and minimizing transaction costs. Max Vijay was awarded the "Golden Peacock Innovation Award 2008" for its unique product, distribution and service strategy. Max Vijay's life insurance product is a 10-year life insurance policy with a long-term savings component, with a minimum initial premium payment of 1,000 rupees and a maximum death benefit of five times the premium payments received in the case of natural death and ten times the premium received in the case of accidental death, up to a maximum of 50,000 rupees for the cheapest variant. After 10 years, the policy terminates and the account balance is paid to the policyholder as a maturity benefit. If the policyholder dies before 10 years but after six months of the effective date of coverage, the beneficiary receives the account balance and the death benefit amount.

Indian Examples: Max Vijay

- Investment in government securities
  - 60% of 1st year premium
  - 90% of subsequent premiums

  - Investment once credited, will not reduce
- Premium from ₹ 1,000 - ₹ 2,500
  - Subsequent premiums ₹ 10
    - No deadline of renewal, No lapsation
- Death benefit
  - 5 X/10X annual pr. + account value (normal)
- Term : 10 years
- Partial withdrawal after 3 years

Retailer channel exploited

15. Summary

Micro Insurance is an insurance system that offers products designed for the poor. The poor sections of the population face a variety of risks. Risk mitigation becomes important as their meagre income and livelihood are dependent on their physical well-being and health. The growing risks in such an evolving marketplace have highlighted the need for insurance in the low income segments. Hence it is defined as a savings solution directed at low income groups with modest premium. The relatively new concept of Micro-Insurance has been on continuous rise for the last decade and is attracting larger amounts of people than ever. Based on the concept of risk-pooling, it can be spread through various networks and channels to ensure the maximum client reach.

Extending insurance to rural India is quite a challenge. Microinsurance is not attractive as the cost to insure the population is high vis a vis the income levels, even though insurance penetration in rural areas is negligible. Additionally to this low income population, is the intermittent power supply, connectivity issues and linguistic limitations and the logistics involved that would plague an Insurer's initiatives.

India is one of the few developing countries in the world that has a special micro insurance Regulation that regulates the suppliers through its special agency for insurance regulation. There are plenty of issues and challenges for sustainable growth of micro insurance in India but insurance companies are looking for feasible ways to provide coverage to rural populations living below the poverty line. If large insurance companies can remain attuned to regional sensitivities and scale quickly, microinsurance offers a huge opportunity for insurers to penetrate new markets and build a more resilient and inclusive economy.

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Consolation Prize

Technical Paper Essay Competition (Pension)

Micro Pensions

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Abstract

The objective of the paper is to understand micro pensions in relation to the demographic changes and the prevailing dependency rates. Analysis of the drivers for development of Pension Markets - disintegration of traditional joint family systems into nuclear families and migration of younger generations from rural area to urban leaving behind the aged rural population who have been left with no access to financial security in their old age when they are unable to work for their earnings - has been made. Contribution of the unorganized sector to the National Income, the need for bridging the gap in old age security measures for this sector compared with as that of their counter part of the organized sector has also been identified. The various of forms of Old Age provisions - Three pillars of Pension – as suggested by the World Bank, the need and necessity for the concept of Micro Pensions schemes - tiny savings at younger ages for the future to avoid the risk of outliving one's own assets for the sectors without regular income and old age provision have also been discussed. Channelizing household

income for old age provisions for a not much financially sophisticated sector with competing financial demands for savings has also been dealt with. The various current micro pension schemes and - Study on micro pension models including Oversees models has been done. Operational Issues and challenges before service providers with inherent qualities of pension schemes such as illiquidity, long term investments, low risk- high safe returns, inflation and related expenses, absence/non availability of data to ascertain the correct annuity factors, gender disparity in longevity, and reaching out the less financial savvy unorganized sector with necessary details have been appraised. The futures of micro pensions and their sustainability in the changing economic scenario and the relevant optimal solutions have also been evaluated. Specific needs for micro pension to female lives have been analyzed. The scope and potential for development of micro pensions for Women has been discussed. Conclusion remarks with innovative ideas and participation by all towards development of Micro Pension schemes have been suggested.

Keywords

Demographic changes – Migration to Urban Centres by Younger generation - Left out Aged Rural Population- - Unorganized Sector - Three Pillars Micro Pensions- Micro Pensions – Operations of Schemes and Models - Challenges and Issues of Pensions and sustainability for the future.- Specialties of micro pensions for female lives – Needs and Potential for Micro Pension market for Women – Conclusion - Innovations in Micro Pension.

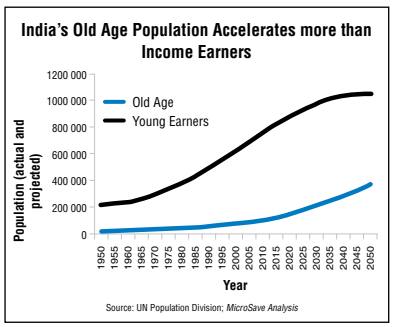
1. Demographic Transitions and their Relevance in Pension Markets

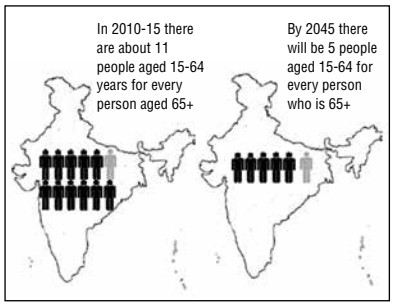
Pension is a form of risk coverage for one's outliving his/her own assets. Earnings increase with age as one grows older and at one point of time becomes nil (as soon as he/she attains superannuation) or becomes flat (provided he/she obtains pension through their gainful employment/ voluntary savings in pension plans).

The demographic environment is witnessing a paradigm shift in life style during the last two decades. The current career models are not being able to fit into a life time employment with a single employer and the occupational pensions schemes are also moving towards defined contributions from defined benefits due to certain obvious reasons such as shift of employment, increase in inflation etc. Women have more access to education and employment thus leading to delay in marriages and the first child's birth. With the segregation of traditional joint family systems that take care of untimely death as well excessive longevity of family members, formation of nuclear family systems and increasing infertility rates coupled with improvement in longevity and rapid urbanization, to commence the old age provision process at younger ages during the period of active employments has proven to be necessarily imperative. The decreasing trend in the interest rates exacerbates this situation still further.

India is recently witnessing urbanization as the main cause for the increase in old age population at rural areas. The percentage of elderly population is expected to be double in the next thirty years particularly in rural areas.

The population moving to urban will also increase to one-half level from the current level of one third. Such a migration of younger population to urban may worsen the living condition at rural for the elderly population with more and more number of persons at advanced ages staying back in the rural areas.





2. Need for Micro Pension

A three pillar model (which was subsequently extended to five pillars!) was developed by World Bank for the old age provision with the first pillar being social security schemes, the second being the pension formal occupational schemes and the third as Private Pension Plans (like Individual Pension Products). Micro pension can be categorized under pillar III.

The landscape of pension arena is predominantly occupied by Occupational Pension Schemes to formal sectors comprising private as well as public institutions. The supply of Individual Pension Products in the market is very much limited. Though life insurance

companies transact these types of longevity products, only a very small number of products are available in the market for purchase. Even if available, the products because of the nature that guarantees come with a slightly higher purchase price, discourages an average informal sector workforce to buy.

The opportunity of employment for unorganized sector work force such as construction workers, drivers, maids, casual daily wage labourers, home based workers, housekeeping, street vendors in post liberalization is improving vast though there is decline trend among the number of persons opting for this sort of employment. The unorganized sector employment opportunities do not aid any social security at old age when the workforce becomes incapacitated to perform any job due to so many reasons, though the organized sector enjoy the security for their old age in many other forms including provision of pension such as provident fund, gratuity and other medical aid facilities etc., On the contrary the predominant unorganized sectors' workforce contribute for the national income as well as national savings through their wider employment opportunities.

The unorganized sector faces the risk of outliving their own assets which mainly take the forms of asset class such as livestock, housing or gold, if they have not saved properly during their shiny days for their old age. They are pushed into the poverty particularly at ages when they are unable to work due to age or health related problems. This is because they put hard labour through their physique during their younger days. Unlike western countries, in the Indian context, at the advanced ages say 60 they are unable to put the same kind of labour as they used to put during their younger days. Particularly taking into account the inflation, even during the days of active employment, the earning capacity or increase in earning capacity is less due to irregular nature of the income leading to less saving capacity for the future, augmenting old age dependency. People at younger ages could not perceive the effect of inflation and erosion in the money value over the time they attain old age and may find it difficult for the means of day to day living.

Thus, unlike formal sector where pensions are provided by the employers either in the form of defined benefit or defined contribution scheme, the insulation of unorganized sector with the income security in their old age poses challenge for the economic viability of savings to accumulate to a sizeable pension amount at old age that too without much liquidity during the term, coupled with the limited supply of Individual Pension Products in the market.

Despite the fact that there is no prescribed date for retirement the problems associated with age or ill-health (which may advance if due to occupational reasons for labourers like driving heavy vehicles, cleaning etc.,) may compel the unorganized sector to suffer without sufficient income at old age relying heavily on their children. Under these circumstances, even with accumulation of other types assets such as gold (with high level of liquidity) or real estate (marketability, high dealing costs and other connected issues) the risk of one outliving such assets is high or such assets have visibility for donation to children in their emergency needs. Such assets have psychological and sentimental vulnerabilities more than to provide for livelihood!

Women work force though normally known for their savings habit, they require old age provision in the form of pension more than their male counterpart due to increase in longevity, lower opportunities for employment in the Unorganized sector, comparatively with more intermittent but lower income(as compared to males) , child birth, widowhood and other family as well as social responsibilities. These make it necessary to bring Women work force under the umbrella of old age poverty eradication through micro pension schemes. Women work force (both formal as well informal sectors) are also strongly influenced by the investment in gold not only as means of savings but also high liquidity associated with it (which they can convert into cash very easily) and particularly those in informal sectors use it for dual purpose –as ornaments as well as security for obtaining credits frequently at the time of emergencies such as hospitalization of family members, marriage etc.

At the time of decline of income, micro pensions aim to provide supplementary regular income the informal sector work force through the formal channels of savings at younger ages into various pension schemes, just because of their illiquid nature unlike the above assets.

3. Micro Pension Schemes

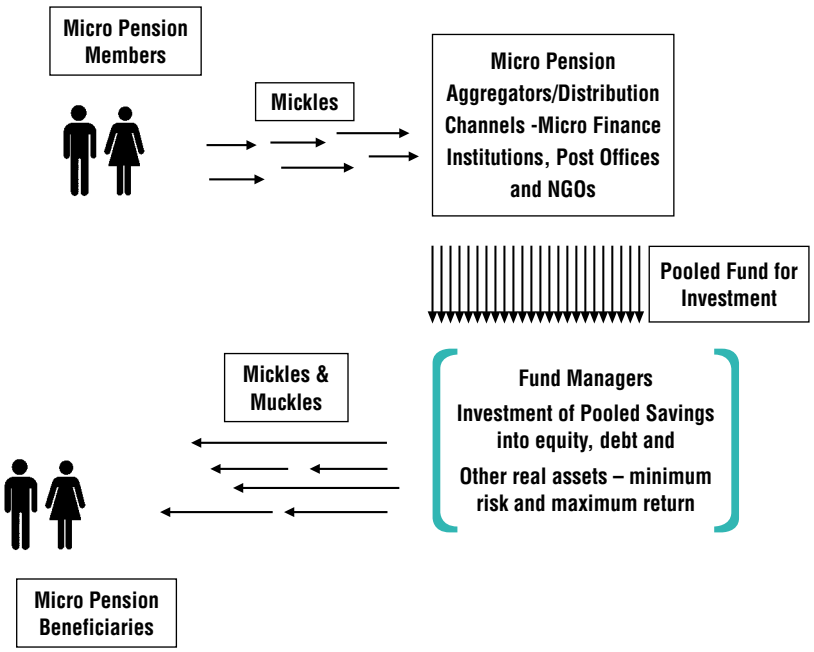
Micro pension schemes are essentially voluntary schemes involving accumulation of savings over a period in which one is actively engaged in some occupation and can apportion a part of his income towards savings for the future. At the end of the period (during which savings accumulate) pensions can be bought with accumulated savings and a portion of

such savings can also be withdrawn. The method works similar to that of an ordinary contributory pension scheme. However micro pension schemes come with more flexibility and liquidity as compared that of the other formal contributory pension schemes. Micro Pension schemes share the risk of longevity among the scheme members.

Mickles and Muckles

Stuart Rutherford, micro finance practitioner coined the word mickles and muckles for the micro pension contributions and pay outs. A series of small contributions are made by the members of the micro pension scheme over a long period say 20 or 25 years which are pooled for investment in various asset classes with the purpose of maximizing the return with minimum risk (pension funds being long term investments are expected to be more secured!). These are returned as a lump sum pay out (Muckles) or a series of small pay-outs (mickles) or a combination of both mickles and muckles.

Micro pension concepts were started almost a decade back, around 2005. With the concept of three pillars introduced by World Bank, the micro pensions are identified with the third pillar. Apart from the routine forms of micro savings through micro finance institutions or community based organizations or NGOs, micro pensions aim poverty reductions through sustainable schemes using the same channels. These types of schemes enable to the poor to build capital through programs initiated by institutions. Micro pensions aim at encouraging families to have financial independence at old age without the burden of having more number of children for old age protection. This reduces the demand for public resources on food, education, health up keep, transport facilities and divests the investment and enables poverty alleviation.



4. Micro Pension Schemes

i) UTI Micro Pension Scheme

This is a flexible micro pension scheme with small contribution ranging from ₹ 50 to ₹ 200 and convenient mode of payments. The scheme was introduced with micro finance intermediaries like SEWA (Self Employed Women's Association), Federation of milk producers in Bihar, Urban Cooperative Bank run by Women, Self Help Promotion for Rural Health and Development. With certain specified target percentage of amount in equity (to earn enhanced returns) the scheme aims to achieve a target return of around 12% after expenses. Contributions are made by the members up to age 55 and pension starts at the age of 58. The pay-out can be phased withdrawal, lumpsum or annuity or a combination of both.

ii) National Pension Scheme (Lite) and Swavalamban

The NPS – Lite is a kind of micro pension scheme, with the initiative took by the Government and is regulated by Pension Fund Regulatory and Development Authority.

The subscription to this scheme is through aggregators who choose the fund managers to maintain the fund. Subscribers receive Permanent Retirement Account Number portable across different aggregators. There is an option to choose the age at which pension payments start like 60. If one wants to start the pension payment earlier at the age of 50, the minimum number of years of contribution should be 20. At the time of retirement facility to withdraw

60 percent of the accumulated contribution is available and the balance can be utilized to get pension payment. If option for withdrawal is made earlier only 20 percent withdrawal is possible. The charges are very nominal that one time charge of ₹ 70/= and annual charge of ₹ 35/= are charged.

To encourage the participation of the unorganized sectors in the pension schemes "Swavalamban" schemes were introduced with co-contribution during the specified number of initial years by Government to the subscribers. The purpose of co-contribution is to incentivize the unorganized sector with the sufficient corpus for the old age provision.

Different types of models of NPS Lite are available like Direct Aggregator, Promoter and Independent Agent Models. The purpose of these models is to outreach the target population by the distribution channels and ensure maximum enrollment by furnishing appropriate information.

The service providers of the scheme has dominant role to play with, right from creating awareness on retirement planning, provision of single window for information, motivation for contribution wherever the pension accounts have become dormant and delivery of final pay outs.

iii) A Few Other Sample Schemes of Micro Pensions:

a) The micro pension scheme initiated by Rajasthan Government for its unorganized labourers like rickshaw pullers, motor mechanics, self employed electricians. The contributions are made by the labourers along with matching contribution deposited by the Government. The scrutiny and processing of applications is managed by Labour Inspectors and the fund is maintained by the licensed fund managers. On attaining age 60 the labourers will get annuity based pension.

b) Abhayahastham pension scheme is a kind of micro pension scheme introduced for Self Help Group Women who in rural and urban areas of Telangana with the aim of providing financial security and income security to the members of the scheme. With an annual contribution of ₹ 365/= (Re.1 per day) along with the co-contribution by the Government, a minimum amount of pension of ₹ 500/= from the age 60 is available subject to fulfilling certain conditions. The membership to the scheme is based on certain conditions and norms. Apart from pension, insurance cover is also available.

c) Kerala Government has initiated micro pension schemes for various informal sector workers like agriculture workers, Coir Workers, fisherman, liquor shop workers and cashew workers etc.

d) Several State Governments have taken initiatives to provide micro pensions under the umbrella of social security schemes for Unorganized workers, Widows and Destitute Women, Dependent Children etc.

The above are a few examples of Government Initiatives and the lists go on. Several NGOs and other private sectors are also involved in micro pension activities. The following are a few among them to cite as examples:

a) A pension scheme for fisherman was introduced by SIFFS with contribution in multiples of ₹ 50 with minimum amount ₹ 50. The scheme called Old Age Security Scheme provides pension at the age of 60 along with the facility for earlier withdrawals on death etc., subject certain conditions. Linked with the Post Office savings rates, these schemes have also the penalty for default.

b) Invest India Micro Pension Services is a private limited company, focusing on creation of platform for old age savings by the informal sector. Technology based schemes are introduced in collaboration with Government Institutions and NGOs. The organization aims at providing low cost micro pension products to the informal sector through modest savings. It has coverage of more than 2 lakhs members across 100 districts in 10 states. It has diversified into retirement and old age provision literacy and insurance also.

5. A Few Micro Pension Models

i) Micro Pension Model of DHAN Foundation:

DHAN (Development of Humane Action) Foundation was initiated in the year 1997. The organization developed a micro pension scheme in 2011 as social development model with the aim of reaching out around 25000 in the next 5 years. The target could be achieved by 2014. The members belonged to different socio-economic patterns, family systems and financial status. Prior to introduction of the scheme, a survey and feasibility study was conducted among 44000 persons on various factors such as income

and expenditure pattern, savings and credit over a period of time. The purpose is to ascertain the status of "willingness and affordability to pay" with regard to occupation and income level. Based on the results of the survey and study need based tailor made products were designed.

Based on the sample study of 3600 and 603 households, it was found that only 6% have access to some form of old age security. Though there is a general hesitation to pay premium for longevity insurance products of micro pension, willingness for contribution was on an average the savings could be around ₹ 100/= (regardless of their income!). This coincides with the minimum under NPS. Land and livestock were predominant assets in rural areas.

The need for old age provision at advanced ages was felt by all age groups. Thinning of family support and tightening of dependency makes members of all ages in micro finance institutions to opt for micro pensions. Younger generation felt much that the family support at old age will be little.

The contributions were collected through Self Help Groups and the field officer from DHAN foundation will attend the Self Help Groups meetings to create awareness and emphasize on the need for pension for old age. The Self Help Group representative will collect the money from the members and will pass it on to Fund Manager for investments. This will facilitate the members avoid travelling to collection centers like banks or post offices foregoing their time, money (wages) and efforts. Transparency was maintained to ensure winning confidence of the participants and receipts in the regional languages were given.

The scheme is a defined contribution scheme and is a group scheme for lives aged between 18 and 55. The members of the group are from the same village and their strength and weakness were combined to achieve a better living and pursuance their occupation – farming. A small savings amount of ₹ 100/ were collected from the members among the various groups and through a federation for all the groups the pension product was purchased from a life insurance company. A single transaction through the federation for all the members of different Self Help Groups achieves minimizing the transaction cost for Life Insurance Company and maximizing the return for the participants. Digitalization also enabled the increase in efficiency.

ii) Micro Pensions Schemes of Grameen Bank in Bangladesh:

The existing financial infrastructures say micro finance institutions were utilized to access informal sector for provision of old age protection or pension. One such example is Grameen Bank which provides micro credit services for the poor who cannot obtain loan from other commercial banks.

Grameen Pension scheme is to address the old age incapacity to earn income for its loan borrowers. Named as Grameen Pension Savings scheme, this requires all the borrowers with loan amount Tk. 8000 to deposit a minimum amount of Tk.50 each month in the pension's savings account. The bank introduced this long term savings scheme in the form of a pension scheme in conjunction with loan scheme. After ten years the savings amount accumulate with considerably higher rate of return. The GPS has deposits in lower denominations. Flexibility as to the payment of deposit on any day of the month and in advance is allowed. The ownership of the capital is retained with the members and withdrawals are also permitted. This enables the members to create a long term asset base.

The scheme is pioneer for many other micro pension schemes and the membership has increased four times within four years since its inception due to demand supply factors. The Grameen cross subsidizes returns on the pensions scheme from other earnings. The network of Grameen Banks is huge and this reduces the transactions costs. It has portability to have transfer to any other Grameen bank. Automatic closure of account due to nonpayment of installment and default penalties are charged on re-activation to encourage persistency in participation. Tax concession is an added advantage for this plan. Coupled with death benefit during the term, the scheme has its own attractions.

iii) Micro Pension Model in Ghana:

Around 80% belong to informal sector and the share of 60+ is expected to increase from 7% to 15% in the next 40 years. With large working population, the micro pensions have the facility of weekly savings, flexible savings aiming the coverage over 500000. The business model uses Telephone Company,

Micro finance institutions including banks, communities or union as distributors. Board of Trustees, Asset Managers, Administrators and custodians to keep the records of the assets are included in the business model.

The use of mobile technology for all communication including identity through bio-metric is done to reduce the costs. Reducing the costs and human mistakes, money collection, accrual of pension and disbursement is done through the automated processes. Mobile phones are used to recognize voices, faces and even ages of the individual and no formal data base is required. A maximum charge of 2.5% of the contributions is charged within which the People's Pension Trust has to manage the administrative costs including fund management. The average savings if EUR 100 per participant per year. Though the entire process can be automated using mobile technology, for introduction of the schemes agents are required.

Segment based products (at least three) to suit customer needs, minimum subscription amount for the scheme to be feasible, returns to cover inflation are the basic features.

6. Operational Issues and Challenges before Micro Pension Schemes

Micro pension schemes are essentially voluntary schemes involving accumulation of savings over a period in which one is actively engaged in some occupation and can apportion a part of his income towards savings for the future. At the end of the period (during which savings accumulate) pensions can be bought with accumulated savings and a portion of such savings can also be withdrawn.

With the challenging demand for sources of income, the members of the micro pension schemes have to save for a longer period with small amounts that entail frequent intervals. The members of the scheme perceive this as too much onerous.

The fund manager will be administering the scheme and unlike other Voluntary pensions schemes under Individual Pension Products, the scheme has to be managed sensitively to make the customers to understand the process (who are financially not that much sophisticated) and involves collections of savings amount during the period of accumulation(again this involves costs). "Illiquidity" i.e., "the fund is not accessible by the members for a long term" is the major issue that makes this process complex. There is also discernment that the pension pertains to formal sector employment.

The returns to the customers of these schemes have to be carefully designed and explained. There is no adequate data available to the fund managers to determine the rate of return based on longevity. The longevity is the main risk which may have parametric errors despite large membership with the concept of pooling. The risk is not predictable with accuracy. The actual experience differs from the assumptions made. The dispersion of actual experience around the expected(average) experience would be higher and the variance may be attributable due to many reasons such as non uniformity in gender, region etc. The bottom layers of the economic group are heterogeneous in various aspects right from their income, needs and their commitment towards the long term savings for future provision.

Right from registration into the scheme, the process continues for collection of contributions, Investment/Reinvestment, maintenance of data bases and payouts that involve costs and all these costs increase in line with the inflation. Thus Post sales service is high in pension schemes demanding for higher costs. Unlike other forms of micro finance schemes the micro pension schemes are individual based and not group based.

The risk appetite for the low income group could be much lower due to tiny savings over a longer period confronting the venture into high risk investments to get a higher reward, necessitating the costs involved in the entire process to be kept at the barest minimum as they may reduce the returns in turn. It is very difficult to find out suitable assets to obtain high real return particularly in the period of high inflation with adequate security to investment. Due to long term nature, reinvestment risk is also pertinent.

The numbers pertaining to simple registration could be misleading and may give a false sense of success rates. The success of the schemes actually depends on the size, duration and frequency and persistency of the contributions.

7. The Sustainability and the Future of Micro Pension Schemes/Models

The administrative costs should be kept as minimum as possible to keep the returns at an optimum level so that the schemes are attractive and the poor find a good value for the money. The administrative costs can be kept under control by leveraging the existing arrangements, resource sharing, and better use of technology, centralized maintenance of records, ensuring

simplicity and flexibility in products' design. Simplicity and flexibility in products' design are crucial factors for wider participation which in turn may reduce the costs indirectly. This may encourage the unorganized sector to participate in the micro pension schemes.

Transparency in administration of the scheme, efficient fund management, proper systems to monitor and control over the contributions and payouts (system based administrations), innovation, education and training to the clients on financial literacy, tailor made products, accessibility at the location of the clients, portability among the various schemes and better flexibility may take the micro pension products to the needy poor attempt at sustenance.

Mobile transfer applications can also be used in the current scenario of expanding network, since they are not based on location. These types of mobile applications will enhance the speed and reduce costs. Mobiles can also act as bio-metric devices for authentication and security of financial transactions. It is available on 24 X 7 bases at the door-steps and the members need not wait in a queue at Point Of Sales foregoing their wages.

Independent regulatory body for micro pensions will bring the aggregators, institutions and fund managers under the control of one authority. Regulations related to contributions, fees, distribution channels, management of the fund and the relevant charges and settlement of pay outs will enhance the customers' faith and participation in the schemes. These types of regulatory schemes pave the way for Grievance Redressal mechanisms for the poor and the needy.

8. Women Segment and Micro Pension

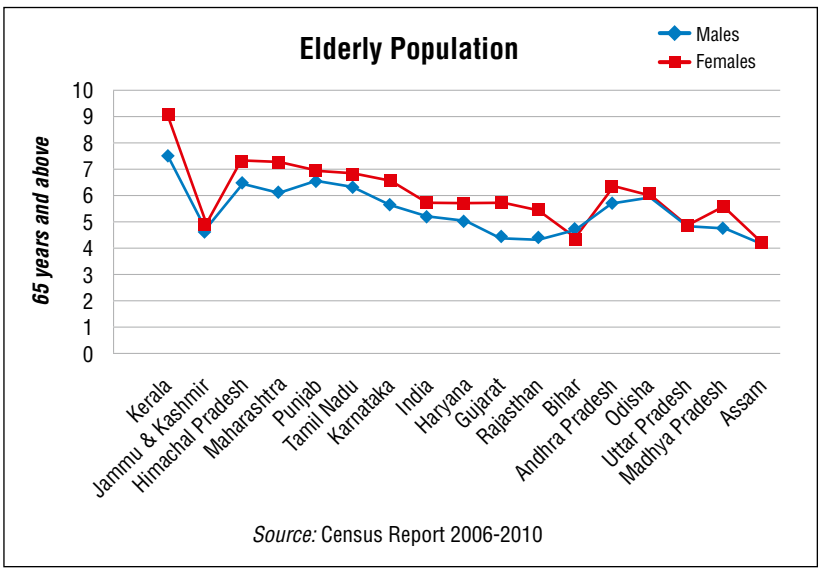
In the various micro pension schemes and models we have seen, we find some specific products like micro pensions from SEWA, Abhayahastham, DHAN foundation are predominantly covering female informal sector. It may look different if we stress that female sector have higher need for micro pensions. But the reality warrants more demand for micro pensions from female segment at their advanced ages.

i) Population Statistics and the Demographic factors:

There is a decrease in the mortality rates (improvement in longevity) as well as fertility rates. Women are more exposed to gender bias, less financial autonomy, inequity in property rights, Widowhood, psychological need for dependence on their children unlike males etc., Women had six children earlier days on an average, now the number has shrunken to two children. Life Expectancy on an average is six years more for women than man. Women who reach age 70 are expected to live more than a decade, thereafter. Increase in life expectancy coupled with the fact that women marry males who are elder to them exacerbates the old age vulnerability for women, due to increasing widowhood. By 2050 it is expected that the number female lives outliving male lives will be around 18.4 million. On an average a women need financial security for a period of around 15 to 20 years after the death of husband. Widows and separated have least financial independence in household.

A feasibility study for micro pension model revealed the fact that more than half of the 60+ women are widowed and their income is one third of what women in age 30-40 earn.

Earlier women were given old age protection and provision by their family members, but owing to changes in demographic patterns (which we have discussed enough in earlier sections) women are left without psychological and sociological support and even without any facility to take care of their health. Their neglected health



Source: Census Report 2006-2010

seeking behavior due to family commitments at their younger ages has its own impact at very advanced ages. Migration of younger population abroad aggravates the situation.

ii) Women and Micro Pensions:

The first pillar of old age viz., social security scheme covers around 3.5 million widows under Indira Gandhi National Widow Pension Scheme. Women under Below Poverty Line were covered under the scheme. Around 120 million of informal workers are women which include segment like unregistered home workers.

Thanks to Micro Finance arrangements which made the unreached poor to have collective strength through Self Help Groups and creating mutuals. The following were concluded by the micro finance organizations with regard to pattern of participation of Women in micro finance and their willingness towards micro pensions:

- Perceived Demand for small savings products compared to other forms of savings like gold (which need money for one time investment and associated fear of theft or loss).
- Awareness on changing demographic patterns.
- Participation in Micro finance activities like self help groups etc.

iii) Micro Pension Schemes for Women:

a) Established in 1974, a Gujarat based Micro Pension Scheme SEWA collects contributions from Women aged upto 55. The contributions are minimum ₹ 50 per month or ₹ 500 per annum. The amounts are invested in UTI mutual funds with 60 percent in debt fund and 40 percent in equities, through individual retirement account. At the age of 58 either withdrawal or conversion to pension is possible. The scheme has been responded well by women segment.

b) With high immunization rate due to literacy, longevity level is high among Women section in Kerala. The elderly care projects are being under taken through health hubs, through partnership between Kerala Government and Private Players.

Finally though more and more women from informal sector participate in micro pensions schemes, taking into account the longevity associated with the segment there are lots of scope for more and more development of innovative products is need of the hour. Women segment are known for their inclination towards savings for future that too with promptness. Micro finance institutions should take into account these aspects while designing micro pension products that the default risk is less from female segment(despite irregular and low income), whereas longevity is more! Sustainable and sturdy pension products specifically designed for women sector without gender disparity will always be welcomed by the women sector.

> Not only member participants but their family members should also be apprised of the micro pension products to encourage participation. The employment opportunity for the younger generation will improve when the elderly population is provided with the choice of regular income in their old age and they can enjoy their time playing with their grandchildren!

9. Concluding Remarks

Micro pension can act as social security schemes if they are integrated with explicit co-contribution scheme that are similar to implicit tax advantages to formal sectors on certain pension platforms. Development of Data bases based on the social security schemes is need of the hour and other population census may enable these longevity products to be calculated with the actuarial perspective- which could enhance the better returns to the participants without necessitating margins for actual experience, thus improvement in returns offered under micro pension products.

Trust is the important factor that plays a very vital role in these types of savings through longevity products. As the informal sectors' participation is more and the scope for the market of Micro Insurance Products (Insurance, Health and Pension) is very vast with the changing demographic patterns, an Independent Regulatory Body exclusively for regulating micro finance Insurance products like life insurance, health insurance and pension products, their price, intermediaries and the institutions setting up of the micro finance insurance products will enhance participation. This will avoid mis-selling, over selling and other

practices. Combination of Health and Pension products can be thought of as Micro - Elderly care through tie up with NGOs, Hospitals and charity institutions. This may act as a complementary to the Social Security Schemes. The income of the poor and needy will be well diversified into asset creation for their basic needs at their old age instead of investment in vulnerable asset classes such as gold or livestock. The old age issues will also be addressed properly through these innovative schemes.

Micro Pension involves large number of transactions with mobility and transfer of small value of money. Uses of technology like mobile phones, smart cards are the smart ways to tackle the issues of large number of small transactions. Differentiated products and flexibility in schemes will make everyone to participate.

Capital Guarantee, Viable incentives to all the Stakeholders, Variable annuities like impaired annuities, Well diversified high risk Investments to get better returns, In-depth market research and analysis by experts to understand the needs of the younger as well post retired generations, experts to advise on retirement plans and effective usage of existing network will make the participation progressive.

Research on micro pension products is to be undertaken for implementation in the future so that today's younger generation may have better coverage for old age provision.

In short micro pensions can be thought of as a bridge between social security schemes and traditional pensions schemes (Pillar III – Voluntary savings), enhancing co- contributions (similar to social security schemes and tax advantages available under some forms of traditional voluntary pensions scheme) and voluntary contributions by the members themselves in the form of savings can make the marketing of these products successful and reduce the burden of social security schemes.

Involvement of employers of the informal sector could also be considered. For example if an informal sector employee stays with the same employer for a longer duration (even if the employment is intermittent), it may be made mandatory for the employer to make contributions towards micro pension schemes - subject to certain minimum number of years put in by the informal sector with the same employer. Such schemes can be motivated by tax advantages for the employers. Also it will incentivize the loyalty of the informal sector employees towards employer. The scheme is viable only on proper maintenance and availability of records.

"Gift-a Pension" scheme can be expanded (which is already available through one of the micro finance institutions) and technology such as internet can be used for identification and incentivization of such programs. Though immediate benefits are not perceived by the micro pension beneficiaries, the benefits in the long standing will prove to be worthy compared to small annual gifts like saris etc., to housekeepers who remain with the same employer for a longer duration say twenty years etc.

Households should think of arrangement/contribution towards micro pension schemes for their workers, drivers, care takers as a part of their remuneration which will form a new trend getting set in the forth coming days.

Not only member participants but their family members should also be apprised of the micro pension products to encourage participation. The employment opportunity for the younger generation will improve when the elderly population is provided with the choice of regular income in their old age and they can enjoy their time playing with their grandchildren!

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7. Discussion questions can be provided at the end of case (optional).

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I/we undertake to accept full responsibility for any misstatement regarding ownership of this article.

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SR. NO.	CODE	SUB CODE	PROGRAM	DATE FROM-TO	FEES FOR RESIDENTS	FEES FOR NON-RESIDENTS	DESIGNED FOR
November 2017							
1	CP	CG2	Compliance Governance and Risk Management in Insurance	30-1 Nov 2017	₹ 12900 + GST	₹ 9300 + GST	Associate / Fellow members of the Insurance Institute of India and the Institute of Company Secretaries of India.
2	CP	EG1	Engineering Project Claims	6-7 Nov 2017	₹ 8600 + GST	₹ 6200 + GST	Officials working in property Lines, audit, oversight and fraud control departments, with a basic awareness about Project Insurance.
3	CP	MI3	Motor Insurance (Own Damage) Workshop	6-9 Nov 2017	₹ 17200 + GST	₹ 12400 + GST	All Levels of Executives from Insurance Companies, Broking firms and Surveyors.
4	CP	YL1	Advanced Program for Young Leaders	13-17 Nov 2017	₹ 21500 + GST	₹ 15500 + GST	Young Managers / Executives drawn from Life Insurance Companies, who are at the junior management levels.
5	CP	PI2	Management of Property Insurance - Engineering Project (Underwriting)	20-22 Nov 2017	₹ 12900 + GST	₹ 9300 + GST	Middle Level Executives from the underwriting department of Insurance Companies.

SR. NO.	CODE	SUB CODE	PROGRAM	DATE FROM-TO	FEES FOR RESIDENTS	FEES FOR NON-RESIDENTS	DESIGNED FOR
December 2017							
6	CP	EG2	Engineering Claims (Non-Project)	4-5 Dec 2017	₹ 8600 + GST	₹ 6200 + GST	Officials working in property Lines, audit, oversight and fraud control departments, with a basic awareness about Engineering Insurance.
7	IP	IG1	International General Insurance Program	4-16 Dec 2016	US$1200	–	Middle level officials of General Insurance Companies or those working for Broking firms.
8	CP	UM1	Underwriting Management	11-12 Dec 2017	₹ 8600 + GST	₹ 6200 + GST	Underwriting Managers and Executives in Life Insurance Companies.
January 2018							
9	CP	MC3	Marine Cargo Insurance	01-04 Jan 2018	₹ 17200 + GST	₹ 12400 + GST	Junior and Middle Level Executives dealing with Marine Cargo from Insurance Companies, Brokers and Surveyors.
10	CP	MI4	Motor Insurance Fraud	08-09 Jan 2018	₹ 8600 + GST	₹ 6200 + GST	Insurance officials working in Motor, Audit, Oversight and Fraud control departments with a fair awareness of motor insurance.
11	CP	MR2	Mega Risk Insurance (Project)	15-16 Jan 2018	₹ 8600 + GST	₹ 6200 + GST	Middle Level Executives in General Insurance Companies dealing in this line of business and also Surveryors and Loss Adjustors.
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