CHAPTER – II

REVIEW OF LITERATURE
2. INTRODUCTION

This chapter presents the review of literature relating to the study of problems area of life insurance and hidden potential in the emerging market to develop the context for the study. Over the last two decades there has been considerable work on various aspect of life insurance. A review of leading scholarly journal & books over the past few decades leads us to believe that there has been proliferation of studies on life insurance area. I have covered maximum possible studies of available sources.

2.1 Contemporary issues

The tremendous growth during last nine years came along with certain issues regarding policy benefits, customer dissatisfaction, ignorance of rural market & backward classes by private players and other issues relating to life insurance growth & operations.

Nalini Parva Tripathi (2006) observed that the transition of the insurance industry from a public monopoly to a competitive environment now presents very interesting challenges, both to the new players & customers. The insurance penetration as well as the size of the average cover is well below internationals averages, providing great opportunities for insurance companies. Currently product market relationship is dominated by personalized selling rendered by tied agents. Developing sensible approaches not only for the co-existence but flowing of multiple channels for sagacious and sensible propositions in product formulation, market segmentation by single distribution network will be an awesome challenge for the insurance companies.
Review of Literature

**FICCI Conference, C.S. Rao (2008)** reported that, there is a wide gap in terms of market potential and its exploitation by the liberalized industry, the consumer did not benefit in the absence of competition in terms of wider choice and competitive pricing and that the reach of the nationalized companies was limited, the range of products offered restricted and the service to the consumers inadequate.

Addressing the issue of Customer satisfaction **Gupta (2009)** observed that Delivery of service is a relatively new term as opposed to ‘distribution’. This is due to realization of fact that insurance product are not just the policy documents, but much more. Provision of after loss service at pre-negotiated rates in quick times could relieve the customer of much of the trauma that follow an unfortunate event. It will not only bring in the real meaning to compensate or to give financial assistant as we know it, but also a great amount of customer delight. After all, what the customer buys is not a policy, but peace of mind from the perceived threats to his life, activities and liabilities.

**2.2 MARKETING CHALLENGES**

Marketing insurance products in Indian market has always been considered to be a painstaking effort for insurers and other intermediaries like agents, brokers etc, especially in life insurance line of business. According to observation of **Easwaran (2009)**, various reasons can be attributed for such a scenario they are:
Pre-privatization challenges
- Lack of awareness among the people about the importance of insurance.
- No innovative products catering to the needs of different customers.
- Slowdown approach on important service areas like claim processing and settlement, policy issuance etc.
- Shortage of highly qualified distributors who can convert the prospects to insured.

Post-privatization challenges
- Increased awareness and importance of insurance among public especially in urban areas compels more customized products and pricing methodology as per the needs of the customers.
- Competition in bringing new clients; and retaining the existing ones.
- Tariff free regime poses biggest challenge in quoting accurate pricing for the risks covered.

Though the coming days for players are not so easy in the marketing space due to intense competition among them, insurers are striving to bring in many marketing strategies to convince the customers and in tapping the business to be stable and remain solvent in the market.

Post privatization and cut price demands all the insurers to be very cautious in pricing the risks that are offered to the customers. Customers have become very sensitive and expectations with respect to the kind of service offered to them by insurers have grown a lot in recent years. Witnessing the current trends in the Indian insurance industry, specifically in the life insurance space, competition among insurers is increasing to a great extent.
for new business; and retaining the existing business/customers has become even more difficult due to the current economic fluctuations, increasing competitors following private carriers penetration in Indian Insurance market and very importantly the impact due to freedom of pricing.

There are certain characteristics which make life insurance purchase entirely different from other products or service purchase. For Insurers it is vital to know the decision making process of an individual, as any effort taken to increase the protection of an individual could more often result in opposite effect.

In his Report namely “The psychology of Insurance Decision Making”, Samuel Babu S (2009) discussed that most people are risk averse for gains and risk seeking for loss. This attitude is evident when individual are willing to take chance, when they can avoid it by buying insurance. Many do not want to buy even government subsidized insurance products which are sold for low premium and the purchaser is not at all under loss. Insurance purchases are not viewed as instrument of protection but as investment. Thus, the moment an unforeseen event occurs, the insured try to maximize the claim amount.

About mis-selling in Life insurance Alok Mittal (2009) observed in his article that “The higher the agent commission on the product, the more the product is pushed and the more strongly it is registered in the mind of the consumer. This was the high scenario before privatization even now it exists in the market. Also much of the selling in India has been done under the tax saving shield of the sections of Income Tax Act. He adds that there is a wide scope to explore the market potential by proper market survey followed by
systematic segmenting, targeting and positioning of product & services offered by various insurance companies.

2.2.1 EMPHASIS ON TRAINING

P.S. Palande and R.S. Shah (2007) observed that marketing which was very low key in the nationalized life sector will be the most crucial function in the new condition. Marketing function encompass expanding existing market or tapping new market and the industry need to undertake measures which will be conducive to both these objectives. The main thrust would be on bringing the customers to the centre-stage, improvement of services and designing new product.

Customer expectations and awareness have significantly increased in recent years, particularly in terms of better and speedy service, accurate pricing and customized solutions. It has become more imperative these days that every customer is serviced based on the customized needs and the type of risk they intend to insure for. In order to achieve the same, it is inevitable that all insurance carriers look for better predictive analysis than the old system based on common pricing models. To have a better predictive analysis, accurate pricing of premium, sophisticated underwriting and knowing the customers play a key role which could enable the carriers to project these features as their key marketing strategy. This document defines how these features can be achieved by insurers by adapting to certain new innovations and changes in the current methodology.

In his article namely Proactive and focused strategies of the Industry, Lunavat (2008) discussed that training helps the companies upgrade the attitude and skill of their workforce for maintaining standards and quality
and is an inseparable component of any growing business. Unfortunately, although large sums are spent on this head in the insurance sector, training still does not figure in the list of priorities of the industry. In addition to taking advantage of the existing facilities to the extent they are allowed to avail of them, the new entities are sure to invest more in this area and rather than rely on the personnel trained abroad, they would like to set up and strengthen training facilities in India itself. This is bound to prove more cost-effective.

**V.S. Rawat (2008)** observed that considering the increasing competition, it would be essential that the Indian insurance market, especially in the Life insurance, continues to remain competitive. All carriers are under severe pressure to provide the best service to the customers and are forced to go in for innovations in order to bring about operational excellence and be unique in the market.

All insurance companies are striving to become front runners in offering innovative products, including specialized underwriting and pricing methodology to attract customers. The most important innovation is to invest in technology to improve underwriting and claims leakage and also to automate their business process in almost all areas of insurance business value chain. All foreign players, with the collaboration of Indian companies, can adapt themselves to the new processes by quickly utilizing their past experience in the international market. Pure Indian players would strive hard to streamline the data that is the foremost weapon for bridging the gap, specifically in the areas of:

- Sophisticated pricing
• Underwriting excellence

• Speedy claims settlement

Every organization is willing to take up these initiatives in order to be competitive in the market, which is directly or indirectly aimed at offering improved customer service, resulting in profitability.

Human resource continue the most vital segment for any organization and great care is needed in recruitment, training and developmental aspect like retention of talent and growth. The insurance business demand personnel of high quality with a different range of skills and emphasis on greater professionalism.

R.S. Shah & R.M. Lunawat (2008) observed that looking at the current market scenario of policy selling, one would like to see greater sense of responsibility and involvement by the insurers in training the work force so that they do a professional job in selling life insurance. Life insurance products are becoming increasingly complicated and unless the agent is fully conversant with the features of the products he would not be doing justice to his job. In their anxiety to enhance the sales force, sufficient attention is not paid by the insurers in the selection and training of the agents. The attrition and migration rate of the agents themselves are matters of concern. Now few professional universities have included Insurance as specialized subjects in academic curriculum. Some has started the joint venture where insurance students are getting advance job offer from few companies.”

U. Jawaharlal (2008) asserts that sense of urgency is the need-based selling of a particular product. This presupposes that the distributor clearly understands the needs of the clientele and makes a good match of the need
and sale. This will go a long way in improving the business retention levels of life insurers. Further, the improvement in the quality of business is certain to bring about a sense of accomplishment for the insurers that would lead to better efficiency levels and also add to their market reputation. There is need for ensuring that the analytical levels of the distribution personnel take a quantum jump and also that they evince a better sense of responsibility in fulfilling the needs of their clients.

2.3 CLAIM MANAGEMENT

The business of insurers is to settle claims, fairly and quickly; and the key to business reputation and growth lies in claims management process and philosophy. Empathy with the claimant or policyholder must not be lost even on claims which are not valid, and benefit of doubt may be given to the policyholder/ claimant. The efforts directed towards repudiation of claims may need to be redirected towards developing abilities to reduce the declinature rates through effective customer education measures as well as adequate risk selection practices. Claim repudiation is one of the most critical issues which need to address. The repudiation of claims deserves to be examined mainly from two angles - one is the legal aspect and the other is the operational aspect. As regards the repudiation of death claims, Section 45 of Insurance Act, 1938 has a major role in deciding whether or not a claim deserves to be repudiated. When Insurance Act, 1938 itself is a time-tested legislation, Section 45 of the Act that enables life insurers to repudiate life insurance claims stood the test of time, withstanding the bitterness of legal pronouncements. The section protects the claimants of a claim by shifting the onus of proving the reasons for repudiation on to the life insurer
in the event of a policy resulting into a death claim, two years after the commencement of the policy while safeguarding the interests of insurer and its other policy holders to call in question the bona fides of the claim that resulted within two years of commencement of the policy. This section also attracted the attention of various committees that examined the provisions of insurance law.

In Life Insurance Corporation of India vs. Asha Goel, Supreme Court observed (2007)\(^\text{12}\) that In course of time the LIC has grown in size and at present it is one of the largest public sector financial undertakings. The public in general, and crores of policyholders in particular; look forward to prompt and efficient service from the corporation. Therefore, the authorities in charge of the management of the affairs of the corporation should bear in mind that its credibility and reputation depend on its prompt and efficient service. Therefore, the approach of the corporation in the matter of repudiation of a policy admittedly issued by it should be one of extreme care and caution. It should not be dealt with in a mechanical and routine manner.”

Further the following recent pronouncements in some decided cases reiterate the gravity of problem of claim repudiations.

“It appears that the insurance companies have a tendency of insuring each and every person under its medical policy without verifying or getting them examined by their doctor only to enhance their premium and business. It’s a sorry state of affairs in which, we have numerous cases wherein, the claims of the insured persons are deliberately and intentionally repudiated under the array of non-disclosure of pre-existing disease” - Case Chandigarh District Consumer Redressal Forum\(^\text{13}\).
“The insurance companies often act in an unreasonable manner and after having accepted the value of particular insured goods, disown that very figure on one pretext or the other when they are called upon to pay compensation. This ‘take it or leave it’ attitude is clearly unwarranted not only as being bad in law but ethically indefensible” - Observations of Supreme Court bench. 14

Though, these statements are with reference to various insurance companies involved, it is open for all insurance companies to draw lessons and redraw their course of action with regard to their respective claims philosophies. The increase in percentage of repudiated cases would be a cause of concern for all the stakeholders of the industry; as insurance being an intangible service, policyholders would be apprehensive of the promises of their insurance contracts being fulfilled.

In order to ascertain the bona fides of a death-claim, investigation into such cases is the only available avenue to the life insurers. However, quite often the job of investigation is considered as supplementary to the job of marketing in life insurance and hence it is more commonly assigned to marketing executives in some life insurance companies. However, these executive needs to be kept informed that the core activity of investigations shall be to ascertain the facts of the case than to depart from the objective of settling the claims. Though, there may or may not be much dilution in the standards of the investigation that is carried out by such in house officials vis-à-vis the investigations carried out by other professionals, it surely lacks the completeness that it acquires if it is carried out by such a professional. There are certain common areas where there may not be much difference in their respective approaches like area of importance to confirm the background of the life assured’s death, cause of death (say possibility of a
suicide, life style etc.); sources of information like neighborhood, family members, family doctors etc. The specific areas that may distinctly differ are reliance on the investigation records of other agencies/financial institutions/insurers.

There are various problems that come in the way in cracking these things like accessibility of records, absence of common data base (of claims under investigation) amongst insurers, confidentiality matters etc, which may be better handled by professionals. Also there is a possibility that the investigation reports carried out by these professionals may be viewed as unbiased by the aggrieved claimants.

Issues of interpretations: The wordings of the policy documents vis-à-vis the interpretation at the operational level do have a bearing in repudiating the claims. Therefore it is necessary that more care is taken at various levels while a claim is repudiated. In order to achieve this, it is also desired to put in place various layers of operational hierarchy before repudiating a death claim. The pronouncement of Calcutta High Court in the following case law speaks of the need for attentive interpretation of the terms and conditions of the policy contract.

**In Prabir Kumar Nath Vs LIC of India (2007)** the respondent company has repudiated the accident benefit claim of the respondent on the ground that injuries sustained are not 100% as per the policy terms and conditions; whereas the policy terms and conditions did not refer to any specific percentage to define what constitutes a total disability. Disposing the writ petition in favor of the petitioner, **Calcutta High Court observed** that there is no pre condition of 100% disability for qualifying for compensation under the policy. It appears that reliance on the percentage before deciding the
claim and its mention in the communication addressed to the aggrieved policyholder is the focus of attention in deciding the case.

Communications to the policyholders at various stages of insurance policies weighs the obligations of the insurers. There needs to be a better clarity in defining roles of various parties involved in the contract. The following decided case law stands as an example in emphasizing the need for a fair communications directly with the policyholders.

**In Delhi Electric Supply Undertakings (DESU) Vs Basanti Devi (2007)**\(^{16}\) invoking article 142 of the constitution, the Supreme Court held LIC of India responsible for payment of claim liability though, the employer did not remit the premiums recovered from the salary of the life insured to LIC of India. One of the points raised in this case law is that employees of DESU were not with the knowledge of the fact that DESU is acting as an agent of employees not that of LIC. Thus, here is a lesson for life insurers to intimate the status, be it legal or operational, of various parties involved in the insurance contract to policyholders directly, especially in schemes like Salary Savings Schemes.

**Trevor bull (2008)**\(^{17}\) asserts that consumer forums or courts, even while recognizing the need for repudiation in legitimate cases, at times provide stiff verdicts against the decision to repudiate. Ability to keep repudiation to the absolute minimum is likely to be a key to business growth in the changing environment where the consumers expect settlement and business reputation is built on settlement rates.
Arman oza (2008) comments that proper care on the client’s part at the point of sale reduces the risk of repudiation of a claim to a great extent. From a consumer’s standpoint, it is extremely essential to be clear on several aspects of the product and post-sale service at the point of sale itself. An endeavor on addressing the fundamental issue of improving the risk consciousness of the population also needs to be undertaken along with other measures to expand the market.

J. Harinrayan (2008) observed that the business of insurers is to settle claims, fairly and quickly; and the key to business reputation and growth lies in claims management process and philosophy. Empathy with the claimant or policyholder must not be lost even on claims which are not valid, and benefit of doubt may be given to the policyholder/claimant. The efforts directed towards repudiation of claims may need to be redirected towards developing abilities to reduce the declinature rates through effective customer education measures as well as adequate risk selection practices. A close watch on claim frauds, and industry co-operation for this, though, would be an important area for us to work towards as the industry grows at impressive rates and reaches unexplored markets.

C.S Rao (2008) indicate that At a time when there is a growing concern as to both quantity of repudiated cases and quality of their respective decisions, there is need for proactive initiatives by insurers as part of their larger business ethics philosophy to let the claimants know about the availability of alternate dispute redressal mechanisms like Ombudsman in all their correspondence. Though some classes of non-life insurance contracts do have arbitration clauses in policy terms and conditions to refer the matter to arbitration in the event of a dispute on the quantum of the compensation on
insured loss, it is not available to cases of repudiations. Hence there is a need to increase awareness amongst all classes of policyholders about the availability of other alternate dispute redressal mechanisms like Ombudsman. Though regulations mandate furnishing of information relating to ombudsman in all policy contracts, it would be prudent to proactively mention this information again in the communication sent informing about repudiation.

The KPN committee (2008)\(^{21}\) on provisions of Insurance Act dealing with the provisions of Section 45 of Insurance Act recommended status quo of the section. Of late, there is a growing concern on the way in which the repudiations are taking place. While recommending the status quo of the section, even the KPN committee mourns “The Committee, while accepting in humility the considerations that had led the Law Commission to recommend amendments to Section 45 of the Act, is of the view…” It indicates the gravity of the situation that this matter deserves its attention at this hour.

Subodh P. Sirur (2009)\(^{22}\) mentions that while it is agreed that not many are given to know about the preexistence of a disease, there is no denying the fact that attempts have often been made to take the Insurers for a ride and even courts have endorsed this view.

2.4 PENSION SECTOR

In his report namely “Life Insurance in India: Emerging Issues” Ajit Ranade(1999)\(^{23}\) discussed that, Despite of huge business done by LIC, life insurance in India spread very thinly & Slowly and its role as mobiliser of long term saving is underdeveloped. The absence of pension coverage to a
vast majority of Indians also points an important gap to be filled by life insurance sector.”

The Pension market in India has been left virtually untapped. According to P. S. Palande (2008), in the USA pension products accounted for 49 percent of the total insurance policies sold for life insurance, while in India hardly 0.25 percent of the market has been covered with pension product.”

To overcome this issue Indian government is coming with new pension schemes under the regulation of newly formed Pension funds regulatory & development authority (PFRDA). R Venugopal (2009) asserts that the new pension schemes by PFRDA for common man are praiseworthy but where is the money for the poor elderly people to purchase them. Young people will get awareness due to these efforts and go in for this scheme but what about people who are just passing later years of their life, who are actually suffering now and who naturally cannot afford the schemes.

2.5 RISKS UNDER ULIP

The IRDA has been concerned about the policyholders making an uninformed decision in respect of the unit linked life insurance products, the most selling products nowadays. The concerns arise on account of various issues relating to the risks they bear; uncertainty in respect of categorization of charges; the charges levied; periodicity of charges; and disclosures on performance. Considering the several features differentiating the linked products from the traditional products, and taking into account the need for protection of interests of the policyholders and the need to keep intact the basic nature of the insurance contracts; the various aspects of unit linked
business were examined in detail and guidelines framed governing the features of the Unit Linked Insurance business in general and the products to be offered there under by the companies, in particular.

The guidelines are intended to enhance transparency, provide better understanding of the product design to intending investors/policyholders and enlarge the insurance cover in a consistent manner and mainly to conform to the medium and long term investment characteristics of insurance products. Insurance companies have been advised to strictly comply with the guidelines and also give adequate publicity to the various features of the Unit Linked Life Insurance Products on their websites and the sales literature for the benefit of customers.

The Authority, while issuing the guidelines had focused on such areas as product design, market conduct, advertisements, disclosures, furnishing of information, rating of unit linked funds etc. The guidelines under the product design stipulate the terminology to be used for unit linked life insurance plans and other vital areas thereby ensuring that the applicants are able to take a proper decision before choosing a unit-linked policy. As the policyholder is expected to bear the entire risk associated with the premium allocated to investments component, the guidelines laid emphasis on disclosures and advertisement. All life insurers should necessarily and explicitly give comprehensive information, using the same font size, in all the sales brochures, prospectus of insurance products, in all promotional material and in policy documents. An advertisement, in particular, should reflect adequate, accurate, explicit and timely information fairly presented in a simple language about inherent risks involved, the risk factors associated
with specific reference to fluctuations in investment returns and the possibility of increase in charges, the fact of premiums and funds being subject to certain charges related to the fund or to the premium paid etc.

In spite of these guidelines, there are complaints that there is mis-selling of the products and that agents promise returns far in excess of what is permitted to be stated and non-disclosure relating to risks that the policyholders have to bear. While it is not possible to police more than two million agents selling these products across the length and breadth of the country, it may be necessary for the Authority to closely examine the commission structure in this product and insist on the agent filing with the insurer as part of the policy document a list of items which he has disclosed to the prospect and the prospect’s attestation that he had fully understood the implication of his investment decision.

2.6 DISCLOSURE OF RELEVANT INFORMATIONS

An insurance policy is valid only as long as premiums are paid and only when it is kept in an “active” state. There are several instances where delay in premium payment may result in the policy being “lapsed” during which period the customer is not covered under the benefits of the policy. This is quite often a major reason due to which customers/claimants are unable to receive benefits which may have otherwise been available to them.

Section 45\textsuperscript{26} of the Insurance Act and its interpretation through the Supreme Court in its few decisions, defines specific circumstances where misrepresentation or suppression of facts may lead to the policy being considered void and the claim being repudiated. The Section 45 also seeks to differentiate the treatment of such suppression within the first two years of
the policy and the period thereafter. While this is most important to consider and merits investigation in certain cases to find evidence of possible misrepresentation / suppression of facts, it may be pointed out that the legal environment may be changing rapidly and providing further grounds to customers to challenge any repudiation made on these grounds. In recent times the consumer forums and lower courts have been more inclined to rule in favor of the consumer even where the misrepresentation / suppression of facts may have been particularly severe and may have had a very significant impact on the rates of the policy Reference may be made to an article by K.P. Narasimhan namely “Amendments to Insurance Legislation” in IRDA Journal of October (2007), where he mentions “There would seem again to be a misplaced perception with regard to the detailed investigation to be made after a claim has arisen that, it is considered, could have well been made at the time of the proposal for grant of insurance What has not apparently received adequate consideration, while accepting the application of the principle of Uberrima fides to contracts of insurance is that (1) at the proposal stage the volume could be unmanageable to think in terms of detailed enquiry, (2) even the most difficult effort could fail to uncover information to check fully on the statements made by the proposer, and (3) time is of essence in handling new proposal and a balance has to be struck by the insurers between advisability of a few more measures of check and the need to be speedy in the disposal of proposals received. In striking this balance the insurers do keep in mind the application of the principle of Uberrima fides and have only very bare checks at the underwriting stage.
U Jawaharlal (2008) argued that Insurance companies need to continue to strengthen the mechanism of collection of premiums from the customer and simplify the process to ensure highest degree of persistency of their portfolio. Innovative modes of collection now need to be commonly used, including direct bank debits, mobile collection units, etc. On a very different consideration, we must also talk about the principle of “Uberrima fides”, or the principle of utmost good faith, on which all insurance contracts are based. This dictates that while applying for an insurance policy the customer must disclose all facts known to her. The insurer would then decide the appropriate rates for the policy (or that whether a policy can be given at all) based on these declarations with or without further clarifications / documentation from the customer. Under breach of this principle (where the customer misrepresents / suppresses facts), the insurer may be placed under an unfavorable position where appropriate rates may not be applied or a policy may be given where none was financially viable. In the financial interest of the insurer (and the interest of other policyholders) such claims may be repudiated and the policy may be considered “void”.

The principle of utmost good faith being the cornerstone of a life insurance contract, there is always a possibility that some people do not reveal all the facts about their health, habit and life style. It can result into high claim ratio for the insurance companies. Concealment of facts may lead to certain insurance frauds. A PricewaterhouseCoopers (2009) (PwC) survey reveals more than a third of the Indian companies do nothing about the frauds. About 32% of the fraudsters are simply warned/transfered/reprimanded, 28% are dismissed and 60% are criminally charged/civil action taken. In most instances, the
fraudster is a person who has a long standing relationship with the victim company. Nearly 31% are agent-hackers, 19% are external suppliers, 15% top & middle management and 8% are customers. It adds Indian laws are inadequate to handle insurance frauds and the Indian penal code is not equipped.

2.7 LAPSATION AND ITS IMPACT

Life insurance and pension plans are mainly promoted as long term financial service products. They are used both as insurance products for getting protection and as instruments of savings and investment to help policyholders meet a variety of life stage financial goals.

However, the likelihood of the policyholder achieving his goals is dependent upon his

- Continuing to keep the policy in force by paying the premiums as and when due,
- Not withdrawing amounts from the policy for other than the intended goals; and
- Not surrendering the policy prematurely for cash value.

This requires a lot of discipline on the part of the policyholder, particularly in modern times, with the availability of other investment options, advice on them and the ever increasing demands on his resources. This will also require continuous engagement by the insurance companies of their policyholders by way of service, education, guidance and follow up.

U. Jawaharlal (2008) studied that the lapsation ratios of several life insurers are illogically high – illogical because when the insurance contract has been entered into voluntarily for a certain number of years, why should
there be justification for terminating it half way through? If one looks at the reasons for such a phenomenon, several factors emerge that make the policyholder unilaterally go back on his commitment. It is even possible that the contract has not been entered into voluntarily but the policyholder has been coerced into it, at least morally. It is not surprising that such contracts tend to experience premature closure.”

V Rajagopalana (2008)\textsuperscript{31} further discussed that life insurer is vulnerable to losses if a significantly large proportion of policies lapse in the early years before the initial expenses and commissions can be recovered. A loss will be made when a policy terminates at these durations even if no surrender value is paid. Also persistently high lapses and surrenders will affect the growth of the company’s portfolio of business and its reputation in the market.

It is to be expected that there will be some lapses, surrenders and other withdrawals over a period in a portfolio of policies. In conventional policies it was convenient to assume that withdrawal benefits would be less than the value of the policy and in the old ways of pricing, assumptions on these could be ignored. Modern pricing methods anticipate certain level of lapses, surrenders etc. in fixing the premium rates and marketing terms. As such, the insurer will make assumptions on lapse rates; and rates at which policies will be surrendered etc., thereby taking into account the losses and profits arising from such transactions. If higher lapses occur in the early years when initial expenses and commissions have not been fully recovered, the office will make more than expected losses on such business.

Life insurance companies are required to submit to the IRDA lapse data, as part of the annual returns. The number of policies which had lapsed and the lapse ratios in respect of non linked business for different companies were
published in the IRDA Annual Report for 2006 – 07. For 2006 – 07\textsuperscript{32}, the lapse ratios, calculated as a ratio of number policies lapsed and forfeited during the year to the mean of in force policies during the year, varied from 4 % to 57 %. Out of 15 companies for which the ratios were reported, 3 had lapse ratios less than 10%, 4 had lapse ratios between 11% to 20%, 5 had lapse ratios between 21% to 30 % and 3 had lapse ratios above 30%.

However, lapses reported as above had different underlying definitions taking into account the period allowed by each company to pay premium after the due date, which varied from 15 days to 60 days. Also for greater insight, companies would analyze lapses in relation to the new business written during a given period, year wise and according to the duration for which premiums have been paid. Further analysis will be carried out by other categories such as type of plan, sales channel, customer profile etc. Recently, the IRDA has undertaken a study of the lapse experience of life insurance companies and it is expected that useful information will be made available on recent experience.

In general, lapses will fluctuate from year to year due to many influences. The problem arises due to many factors some of which are external and therefore beyond the control of the insurance companies such as macro economic factors, changes in tax laws, availability and emergence of alternate investment options and customer specific features. Some others are well within the control and influence of the insurance companies such as product design and choices, marketing and distribution strategies, incentive framework, supervision and control.

Mr. Amitabh Verma (2008)\textsuperscript{33} argued that Past investigations show differences in the experience of early lapses due to one or more of the
following factors. An individual’s decision to buy life insurance and maintain it by payment of premiums is influenced by a number of personal factors such as education level, socio economic background, age, gender, marital status etc. besides his ability to save. Studies on lapses in the past have shown significant differences in experience between business coming from rural and urban socio economic backgrounds. It is possible that to some extent these differences are attributable to lack of communication, access to service etc. in rural areas. Within the rural market, different products may be sold to different market segments and it will be important to know whether the lapse experience in the rural market is different for each of these products compared to the urban market and the reasons for the same. In particular, rural products which have been specifically designed to meet the regulatory targets for rural business will experience different lapse ratios. Data shows that lower value policies – low sum assured and / or low installment premium have higher lapse ratios. While a small proportion of such lapses could be due to malpractices, policies purchased by people with limited resources or from low income groups are more prone to lapses. Financial difficulties of the policyholder play a significant role in policy lapsation. Potential for higher lapses from these segments indicates the need to better understand the needs of such segments and serve them with appropriate products and services, rather than neglecting them in the sale of life insurance products.

V Rajagopalan (2009)\textsuperscript{34}, Consultant Actuary, ICICI Prudential Life Insurance Company Ltd asserts that employment, income and inflation levels, and their changes from time to time will have a clear impact on the people investing in and maintaining their life insurance policies.
Government policies with regard to taxation and fiscal incentives for life insurance premiums and benefits significantly influence people taking life insurance policies and maintaining premium payments”. He continued that Economic growth in the last two decades has opened up many other investment avenues and options such as mutual funds, direct equity, property etc. for the average person and for the affluent sections of society. This would have considerable impact on how an individual used to look at savings and investment which were mainly through bank deposits, post office schemes, PF, PPF and conventional life insurance. Tax concessions under section 80C are also available for many of these savings and investment vehicles. Thus there is very high level of competition for personal savings from the various retail financial service providers and their products.

2.8 PRODUCT DESIGN AND CHOICES

Insurance companies have a variety of insurance plans and customers buy different plans for different purposes. It is reasonable to assume that the withdrawal experience will be different for different plans. For example, pension plans will have better persistency compared to other plans of insurance, as these may have been affected as long term policies with the objective of building up a corpus to meet retirement income needs. Lapse experience may differ between types of plans depending upon factors such as the needs which are met (e.g. pure protection, mortgage cover, saving), term of the policy and size of premium. The experience of unit linked business in the last nine years has shown differentiation between single premium products sold to high net worth customers as investment products.
and regular premium products sold to the mass market as savings products, with the former showing relatively lower persistency.

Past studies show that the choices exercised by the customer such as frequency of premium (yearly, half yearly, quarterly and monthly), method of premium payment (deduction from salary, debit to the bank account through banker’s order or ECS, or by the policyholder by cheque or cash at the counter) result in portfolios reflecting different experience according to these factors. Quarterly and monthly modes of payment tend to have higher lapse ratios.

While procuring life insurance business for the company, the agent is trusted by the prospect to advise him suitably, keeping his circumstances and needs in mind. While advising a prospect, the agent should be influenced solely by the needs of the customer and not by the amount of commission he will get after the sale. If the policyholders are sold policies which meet their needs, they are not likely to lapse. He is also bound by the IRDA code of conduct not to cause termination of an existing policy with a view to sell a new policy.

In many of the early lapses, it can be seen that the expected role of the agent is compromised. The quality of training and motivation provided to the agents and their supervisors and the alignment of incentives and disincentives to persistency criteria will go a long way in bringing down early lapses due to factors attributable to the intermediaries. In the complaints relating to mis-selling of unit linked policies some of the causes of policyholder dissatisfaction relate to non disclosure or inadequate disclosure of the various charges and the obligation of the policyholder to pay premiums for minimum number of years. Through a circular issued by
the *Life Insurance Council (2004)*, Life Insurance companies are required to provide benefit illustrations for all products, to customers directly or through the agents. The IRDA has recently stipulated that, in the case of unit linked products, the benefit illustrations provided to the prospect / policyholder in the prescribed format should be signed by the prospect / policyholder and the sales person of the insurance company. In the case of health insurance, there are different plans and riders covering e.g. critical illness, hospitalization, comprehensive medical reimbursement, specific diseases like cancer, diabetes etc. These policies differ in the scope of coverage and there are further limitations such as waiting period and exclusions some of which will be general and others which will be specific to the life assured based on underwriting. In order to make the customer understand what is exactly covered in the plan / rider together with the limitations as described above, additional efforts will have to be made during the sales process. The training of the sales staff and agents should take into account the special characteristics of the health insurance products for them to effectively communicate to the customers.

Some insurance companies have the practice of sending along with the policy document, additional materials such as Key Features Document, FAQs etc. explaining the product, terms and conditions in simple language for the customer to understand what he has purchased. Also some insurance companies selectively call their policyholders after sending the policy to obtain feedback and also use the opportunity to answer their questions, if any, on the policy. There still remains the question, namely, how many policyholders really take time to read their policy document and other informative materials provided to them by the insurance companies. In this
area, on-going efforts are required by the insurance companies, Life Insurance Council and the IRDA, to raise the level of awareness and involvement of the customers.

**H.O. Sonig (2008)** mentioned that rather than chasing fresh prospects, insurers should also concentrate on long term retention of the existing policyholders, which is certain to lead to reduction of expenses as well as growing reputation & at the same time they should look for Customer centric products.

**Arun agarwal (2009)** remarks that the free market not only brings in an element of competitive pricing but also stimulates, creates and boosts the development of out of the box solutions to manage Enterprise group life risks. All the life insurance companies transact significant volumes of business through alternative distribution channels such as banks, other corporate agents, direct marketing etc. There are considerable variations in the marketing strategies adopted in the sales through these channels, products sold and the market segments covered. Accordingly there will be variations in the lapse experience of the business transacted through these channels which need to be investigated separately.

### 2.9 RURAL & SOCIAL INSURANCE

70% of India live in rural areas but have no access; or have negligible access to insurance. Due to wide geographical disparity and high distribution costs, insurers have been cautious of venturing into this territory. Coupled with a tariff regime which assured them of good profits, they had been concentrating only on the urban market.
According to a report only 20% of insurable population of India is covered under various life insurance schemes. A recent study indicates that about 70% of the populations in the rural area do not have life insurance.

In his article about rural insurance distribution B Narayanan (2008) observed that when it comes to distribution of products at rural areas, normally two issues come into reckoning. One, to reach every market and Second, the cost of distribution. The strategy for micro insurance in rural India should factor in both distribution and the reduction of transaction cost. Managing the trade off between these two is critical for the industry.

The IRDA notifications regarding obligations of insurers to rural and social sectors have forced the insurers to look at this hitherto unexplored market. With detariffing and recession affecting the premium income and profitability of the insurers, it has become extremely important to look for blue oceans and develop new markets. With increasing rural incomes and improving infrastructure, rural and micro insurance offers immense possibilities. But with opportunities, this sector throws various operational challenges as well, for the insurers. We will be looking at some of these challenges.

**2.9.1 PRODUCT CHALLENGES**

According to J. Hari Narayan (2009) Chairman of IRDA, Currently there is not much differentiation of products for urban and rural markets. The products have been designed as “one size fits all”. This needs to be relooked. The product designers have to understand the needs of the target population and design accordingly, and for that they need to understand the psyche of the people.”
Risks faced by the social sector and rural sector can be broadly classified into life-related and livelihood-related. Risks related to life would include Life insurance, Personal Accident insurance and Illness/Health insurance. Risks related to livelihood would include Livestock, Agriculture and Property insurances. It would be advisable initially to offer products covering these risks.

One major road block insurers face in these types of insurances would be absence of historical and empirical data or if the data exists, unreliable data. This results in higher premium for the customers which would then result in failure of the product. The pricing should be done keeping in mind the buying power of the community and should leverage on the law of large numbers. It would make more sense insuring a large group than a single individual. Further, the viability should be looked on a long term basis of minimum three years instead of making profit in the first year itself. The insurer should instead concentrate on building the data and gain experience in administering such policies. It is always advisable to start on a pilot project basis and then replicate it on a larger scale based on experience. This will give them an advantage to tap the huge untapped rural and social sector market. The terms and conditions of the policy should be simple to understand and with minimum exclusions. Insuring large numbers would preclude the risk of anti selection and to include more risks like pre existing diseases in case of group life insurance.

K. Gopinath (2009)\textsuperscript{39} writes that while there are problems of adverse selection and possible inherent fraud associated with several classes of rural insurance, they can be overcome with a little more application and persuasion.
2.9.2 MARKETING AND DISTRIBUTION CHALLENGES

India is a large country with wide geographical disparity. Reaching the target clients can be a major challenge. Further, community based insurance schemes work largely on trust. Similarly, the premium being very small, the collection and distribution expenses end up being larger than the premium itself. This problem can be mitigated to a large extent by tying up with intermediaries who have considerable presence and influence in target areas.

2.9.3 UNDERWRITING CHALLENGES

In the absence of historical/empirical data, the underwriters find it very difficult to accept or reject proposals. What loading to be charged or what discounts to allow is a perennial problem facing them. The thumb rule would be to go for large groups to avoid anti selection. In the absence of past claims data, similar projects can be taken as reference for pricing. Past experience of insurance companies who have already ventured into this territory may also be considered. Hence a first hand market experience would be advisable for the underwriters.

The back office processes need to be redrawn. Because of the wide geographical disparities and distance from the branches, there could be a time lag between the actual premium collection and receipt of premium at the back office. Also, since most of the collection would be in cash, there is a danger of fraud. Further, cover notes need to be avoided as there is a danger of back dating after the claim has occurred. To decrease cost, cover note cum policies can be issued at point of sale. The date of inception of the policy could be 15 to 30 days from the date of issue of cover note cum policy, to preclude any possibility of fraud. In case of community health insurances, closed loop of network of hospitals along with pre determined
tariffs should be negotiated. Where the number of insured’s is very large, along with technology, various preventive measures like health camps, training on good hygiene, steps to prevent epidemics, availability of doctors for consultation, etc. should be considered.

2.9.4 CLAIM CHALLENGES

Geographical outreach poses a major problem for the claims team. The size of claims could be very small. There is also a serious problem of availability of Surveyors/Loss assessors. It is always better to tie-up the claim process before issuance of the policy. The fact that most of the insured will not be able to understand the terms/conditions and exclusions of the policy should be factored in the claims process.

2.9.5 CHALLENGES FOR RURAL DISTRIBUTION

- High costs of rural distribution on account of travelling, creating awareness/educating and motivating rural customers to buy insurance
- Building faith about the company in the mind of the rural public
- For all rural oriented schemes it is very essential to ensure that the last mile touch point is closer to the customer. At present the customers are not very knowledgeable about the different products offered, and in some cases are not even aware of the government support available by way of subsidy in premium to protect their lives/health/ crops from insurable risks. Finally, rural and social sector insurance should not be approached as a legal or statutory requirement, but as a business opportunity. With proper safeguards, this sector can contribute immensely to the top line as well as bottom line.
2.10 INSURANCE DISTRIBUTION SYSTEM

The entry of the new players, the consequent expansion of offices, new channels of distribution, increase in number of tied agents along with the increasing awareness and acceptance of insurance have all contributed to the massive expansion of the insurance sector in the last nine years.

N.M. Govardhan (2008) asserts that time-tested distribution channels still have a key role to perform for a successful insurance business, especially in emerging market. The persistency rate in Bancassurance, due to the continuous contact with the client is better than in other channels.

Despite the emergence of new channels of distribution, tied (individual) agency channel remains the foundation of the sector, still contributing a lion’s share of the business being generated by the insurers. On the life insurance side, the new business premium procured by the tied agency channel amounts to 89% of the total in the year 2006-07. The number of life insurance agents has increased from around 8 lakhs in the year 2000-01 when the sector was opened up to private insurers, to roughly 20 lakhs by the end of the year 2006-07. Out of this the number recruited by the new private insurers is around 9 lakhs, the remaining 11 lakhs being with the public insurer LIC.

Among the new channels the corporate agencies had performed particularly well with a prominent share coming from the bancassurance. In the year 2006-07, corporate agents had procured 7.3% of the total new business premium mobilized, two-thirds of which had come from the bancassurance. It has however been the experience in the sector that while the new channels have contributed to the business expansion, the expected decline in the distribution costs which was one of the objectives of allowing them to
operate did not materialize to the desired extent. On the contrary, the widespread perception in the sector points to an increase in overall distribution costs, though the first year commissions have seen a steady decline as seen in the graph below:

Chart 2.1: Commission Paid as percentage of Premium

Chart 2.2: Participation of various distribution channels for year 2006-07

It is observed that huge distribution expenses are incurred under heads other than commission towards items such as reimbursement of agents’ expenses, lead generation, infrastructure, performance based incentives, competition
prizes etc. It is also learnt that inordinate amounts are being paid towards references/leads obtained from referral entities as well as third parties.

2.11 Risk Based Capital for Life Insurers (Solvency Margin)

RBC represents an amount of capital based on an assessment of risks that a company should hold to protect policyholders against adverse developments. Capital requirements for the insurance industry are being revised in many jurisdictions worldwide. From being based on a simple formula approach, capital requirements have evolved to follow a more complex risk-based approach where internal models developed by companies are being used to assess unique requirements. The latter approach referred to as the Risk-Based Capital (RBC) approach, links the level of required capital with the risks inherent in the underlying business. RBC represents an amount of capital based on an assessment of risks that a company should hold to protect stakeholders against adverse developments. There are several reasons why RBC has achieved such prominence in the insurance industry. The economic conditions have become volatile worldwide which necessitates deeper evaluation of market risks. Lower interest rates are causing guarantees to bite. Greater transparency is now being demanded by consumers. Regulators have become proactive and increasingly concerned for protection of policyholders and promoting good risk management practices. Rating agencies are beginning to expect firms to have operating economic capital models. The shareholders have become more financially sophisticated and demand greater analysis of their capital invested.

Mr. SP Chakraborty and J. Anita (2009) studied that current regulatory framework in India as per the existing regulations; the required solvency capital to be held by Indian insurers is based on a simple factor based
approach expressed as a percentage of reserves and sum at risk. Insurers are expected to maintain a 150 per cent margin over the insured liabilities. At present, a few companies have started following the RBC approach as an internal requirement by their joint venture partners or an initiative of their own to align with the global practices.”

2.11.1 Solvency Framework

The International Association of Insurance Supervisors (IAIS), which sets standards for national insurance regulation worldwide, has taken another step along the path to establishing a global solvency standard. The IAIS presented a coherent, risk-based methodology for setting regulatory requirements, including technical provisions, when determining required capital in a risk-based solvency regime. It also considers the more qualitative components of governance, such as market conduct and disclosure requirements. This is illustrated in the figure below:

![Figure 2.3: Global Solvency Standards](image_url)
The insurance supervisor may need to have adequate power to require insurers to assess and manage risks, and to set regulatory financial requirements to protect policyholders. Regulatory financial requirements should be risk sensitive to provide incentives for optimal alignment of risk management. There may be a number of solvency control levels that trigger appropriate and timely intervention by the supervisor. The corrective actions that a supervisor might require should include options to reduce the level of risk to which a company is exposed, as well as requiring it to raise more capital.

**Capital Requirements:** The purpose of capital is to ensure that obligations to policyholders can be met as they fall due and technical provisions remain covered, despite adverse conditions. In other words, capital is needed to absorb unexpected changes in the values of assets and liabilities that a company can remain solvent. The calculation of risk-based capital involves identifying the key risks and quantifying these risks.

2.12 EMERGING RISKS OF LIFE INSURERS

The capital required by a life insurance company can be broadly classified as risk capital and working capital. While risk capital covers day-to-day risks of an insurance company, the working capital is required to support the ongoing business strategy of the company. The significant risks faced by insurers are:

**Insurance risk**

Insurance risk arises due to the inherent nature of the business that is underwritten by life insurers. Insurance risk refers to the fluctuations surrounding the occurrence, timing and amount of insurance liabilities.
These risks relate to uncertainties over expenses, mortality, morbidity, lapse rates and rates at which policies are made paid up.

**Credit Risk**
Credit risk is a risk due to the uncertainty in a third party’s ability to meet its obligation towards the insurer. Third parties include reinsurers, companies where the insurer’s operations have been outsourced and firms where the insurer has invested its assets.

**Market Risk**
Market risk is the risk due to adverse market movements that a firm may be exposed to. It creates fluctuations in income, value of its assets or liabilities. Movements in the level of financial variables such as interest rates, equity and property prices, may effect a change in the value of asset which may not be matched by a corresponding movement in the value of liabilities.

**Operational Risk**
Operational risk can be described as “the risk of loss, resulting from inadequate or failed internal processes, people and systems, or from external events”. In recent years, it has been widely accepted that operational risks are significant but these are difficult to quantify. They include risks like internal and external fraud, business disruptions and system failures, transactional processing failures etc.

**Liquidity Risk**
Liquidity risk is generally seen to arise from short-term cash flows where insufficient liquid assets are available to meet policyholders’ obligations as and when they fall due. This includes the risk of having to secure funding at excessive costs or realise assets at depressed values.
**Group risk**

When the insurer belongs to a group of companies, group risk may arise when the actions of any one company adversely affect the reputation or the financial soundness of the insurer. It may arise if there are internal loans from within the group or internal reinsurance treaties.

Different approaches to RBC

Primarily, there are three types of approaches that are emerging under the new RBC framework:

- The first approach is where specified factors are to be applied for each of the identified risks on both sides of the balance sheet. This is known as the total balance sheet approach and this methodology is being followed by USA and Singapore.

- In the second approach, specific scenarios are used by the companies to calculate surplus/deficit and hence the required capital. The Individual Capital Assessment (ICA) methodology followed in the UK is a good example of the second approach.

- The third approach is to allow the companies complete freedom to use their own internal models and their own scenarios to calculate the capital requirements. Switzerland has adopted this methodology.

Many a time, a combination of the above approaches is followed to improve risk based capital calculations and generate cost efficiencies. Generally, the regulators require more capital than the calculated RBC and the margin for extra capital depends on how detailed the calculation was.

Identification and quantification of risks are challenges for Indian insurers due to lack of data, lack of technical expertise, high cost of setting up risk and implementing risk measurement modeling techniques and limited modeling of asset returns.
Developing a comprehensive framework comprising of valuation of assets, liabilities, their interaction and solvency capital would be critical. Addressing the problem in a holistic manner is essential to provide the total framework. While developing the framework, the regulator will follow a consultative approach and involve the industry players.

Alam Singh (2006)\(^{43}\) observes that for successful implementation of risk based capital regime, a collaborative approach is very essential as has been evidenced by the experience of various countries that have already brought in these reforms.

Ashvin Parekh (2009)\(^{44}\) emphasizes that the solvency models presently being practiced in any of the developed Markets may not be easy to be replicated in the Indian insurance domain; and adds that they may have to be tuned suitably to be applicable in the Indian scenario.

All the concerned parties will face initial cost implications for RBC implementation. As most of the companies are new and yet to break-even, in such a scenario, the solvency levels of these companies may be affected by the additional RBC costs. Hence, a separate model can be used for smaller companies and a compulsory RBC framework used for larger companies. For the regulator, RBC implementation would imply increased costs due to ongoing monitoring of insurance companies.

An impact on investment strategies, taxation, solvency, capitalization, product development, etc is anticipated, making it vital to ensure that before implementing the new approach the expected behavior of the companies is in the direction desired for major factors. Due to limited availability and illiquidity of long-term assets there is a high degree of mismatching risk and reinvestment risks for insurance companies. This may put additional strain
on the capital requirement for certain products that may make them uncompetitive. Companies that have sold varied guaranteed products might find their capital requirements increasing further in the new RBC regime and hence might have to reassess their product strategy and pricing. The present investment guideline\textsuperscript{45} for insurance products is stringent and leaves limited scope for allowing insurers to make optimum investment decisions. This implies that under RBC framework, unless the investment guidelines are relaxed, the insurers would find it difficult to match assets and liabilities and to make optimum choices.

A pressing issue which needs to be addressed is ‘whether internals models should be allowed in India?’ It leads to significant increase in the cost to supervise and regulate. It involves a substantial dependence on the office of the appointed actuary. As such a system has both advantages and disadvantages; the regulator must evaluate the costs that would have to be incurred in allowing for such a system. If used properly, such a system can improve the risk management system and may foster efficient capital utilization within the companies but if abused, and then the companies may hide major risks and may go under-capitalized. Although the current solvency regime in India takes into account the various risks of insurance business through application of a formula approach on a gross basis, there is a need to cut up the basis into different risk elements in order to assess the sufficiency of current capital requirements relative to what is required as per the principles of risk based regulatory supervision. The ‘one-size-fits all’ approach does not address the fact that different insurers have acquired different levels of exposures to financial risks. This system also fails to address issues affecting the solvency such as,
• the significant fall of interest rates, globally and locally
• the significant and on-going improvement of mortality in most markets
• the recent fall in global and domestic equity markets
• the number of non-performing assets, etc.

The financial impact of many of these ‘risks’ can however be quantified, and the impact on the solvency of an insurance company can be analyzed. Quantification of some of the risks would help to avoid unpleasant surprises. RBC has the technique to quantify such risks and convert into capital requirements.

2.13 PROBLEMS WITH CRUCIAL TERMS & CONDITIONS

Life insurance policy is a document which expresses the contract between the insurer and the insured. Most of the insurance companies have standard forms of policies with standardized policy conditions in respect of various plans of assurance offered by them. The policy document, to be enforceable by law, is to be signed by the competent authority and duly stamped. The preamble of the policy states that the proposal and declaration signed by the party form the basis of contract. The form contains a schedule which gives all essential particulars of the policy like name, address, plan of insurance, premium, amount of insurance, etc. on the back of the policy, the standardized terms and conditions applicable to all persons insuring under a particular plan are printed. Any special conditions imposed are indicated by endorsement. Some of the most common and important conditions and privileges which form a part of the policy document, and their significance, are narrated below:
DAYS OF GRACE

Days of grace or grace period is the ‘extra time’ given to the policyholder for payment of installment premium after the due date, during which the policy remains in force. It is normally provided for a period of a fortnight to a month. Grace period is meant to be a convenience to the policyholders, some of whom may not be able to pay the premiums on time due to certain preoccupations etc.

REVIVAL OF POLICIES

A lapsed policy can be brought back to life through revival, as if it is a fresh contract, subject to certain restrictions with regard to the period of lapse etc. The policyholder may however be required to submit a fresh set of medical and other requirements/declarations at the time of revival. For the purpose of a claim too, the policy may be treated as new and Sec.45 of the Insurance Act, 1938 be applied.

SURRENDER AND PAID UP VALUE

Sec.113 of the Insurance Act provides for accrual of certain benefits to policyholders even if they are unable to keep their policies in full force by payment of further premiums. If premiums for at least three consecutive years have been paid, there shall be a guaranteed surrender value. If the policy is not surrendered, it shall subsist as a paid up policy for reduced sum. The policy conditions usually provide for a more liberal surrender value and paid up value than those secured by the statutory provisions.

POLICY LOANS

Policy loan is a ready source of borrowing to a policyholder, in a financial contingency. It is paid by insurers against the surrender value accrued to a
policy. Policy loans lend liquidity to contracts which are otherwise ‘frozen’ during the term of the policy. From the insurers’ point of view, they add to the marketability of the insurance products while also being an avenue for secure investments.

**NON-FORFEITURE REGULATIONS**

While grace period is meant to be a convenience, non-forfeiture regulations provide help to policyholders who are unable to pay premiums due to temporary financial difficulties. Nonforfeiture regulations allow additional time of, say, six months or a year for payment of premiums on a policy, even as the risk under the policy continues to be covered. Insurers offer this privilege after the policy has been in force for a few years and is not offered on term assurance and some of the ‘high risk cover’ policies.

**PREGNANCY CLAUSES**

On life insurance policies issued during the pregnancy of a female proponent, life insurers apply this clause to exclude coverage of pregnancy/child birth related deaths. However, with the advancement of medical technology, the relevance of these clauses is gradually reducing. But, life insurers may apply these clauses to those female lives who reside away from medical facilities that are potentially prone to risks of pregnancy/child birth related deaths. If data pertaining to pregnancy risk in a particular region is not available, insurers may apply these clauses to the female lives of the region.

**Riders**

It is possible to tag-along coverage of additional risks to the basic life product on payment of additional premiums, subject to certain conditions
and restrictions. Such add-ons like accident riders, critical illness riders, premium waiver riders in case of minor life policies etc are quite popular and more such riders are coming into vogue. Riders are complex by nature and are often not properly/fully understood by the parties concerned. This causes complaints and legal disputes at the time of claims and calls for defining and interpreting the coverages and exclusions sharply.

The most popular and perhaps the most ancient of all the riders is the accident benefit rider which provides for payment of additional sum assured in the event of death or permanent disability by accident.

**SUICIDE CLAUSE**

As per Indian law suicide is not a crime, but attempt to suicide is a crime unlike in English law where suicide is a crime. Hence, contracts of insurance that agree to pay the sum assured even in the event of the death of life assured due to suicide are not against public policy. But, to avoid a possible moral hazard and adverse selection, insurance companies do place a restrictive clause by not covering death as a result of suicide up to one year from the date of commencement of policy or date of issuing of policy whichever is later. However, provided a due notice is received, life insurers protect the bonafide interests of the third parties who are having an interest in the life of the life assured. While the former dissuades the life assured to be not magnetic of the benefits of life assurance by committing suicide, the later protects the financial interests of third parties as life insurance policies are also used as tools of collateral security.
SPECIFIC CLAUSES ON FEMALE LIVES

Certain classes on female lives such as females in the age group of 20-35 who have no earned income are susceptible to moral hazard. To avoid this risk, insurance companies do impose these clauses excluding coverage of accidental death in other than public places.

OCCUPATION RELATED CLAUSES

To exclude the risks that are closely related to the occupation (like that of a pilot whose occupation is prone to aviation risks) of the life assured, insurance companies do levy these clauses excluding the risk coverage owing to the death of the life assured during the course of employment. Ex: Aviation clause, divers’ clause.

LIEN CLAUSE

In respect of certain types of high risk life insurance policies where insurers have a lower level of comfort due to the adverse disclosures made in application for life insurance and where insurance coverage cannot be denied based on such disclosures, life insurance companies do impose lien clause which could either limit the liability of the insurer during a specified period (like 50% of sum assured during first year, 75% in the second year and 100% from the third year onwards); or defer the coverage for a specified period (like no life cover during first year of the policy). Life insurers also reserve the right to impose a clause during the term of the policy through a clause based on the future occupation that a minor life may engage in. Under the current clause, insurers require the minor life to notify them in the event of minor life engaging in hazardous occupations. On receipt of information from the life assured on his reaching the majority or on his joining the
services of hazardous occupations, life insurers may apply such occupational clauses as deemed necessary.

2.14 HEALTH INSURANCE SEGMENT

Health insurance is the emerging segment in both life and general insurance. As a class, it has surpassed several others although it is of a more recent origin. The rapid growth that it has been recording in recent times also speaks volumes of its importance. In a country where the total coverage of the population under any form of healthcare protection, including state provided and employer-provided schemes, does not go into double digit figures; a sustained growth is welcome.

Considering the huge potential in the country as also the growing income levels and other visible growth, insurers should ensure that health insurance continues to register a steady rise in the near future. In order to achieve this, there is need for widening the client base – not merely by marketing strategies but by ensuring that more and more people understand the importance of having in place proper health insurance coverage. This would be possible by enhancing the distributors’ skills and also ensuring that all the other parties involved viz. the third party administrators, the service providers etc. are geared up to meeting the challenges of this sensitive area of operation.

The real test of success for any class of insurance lies in its ability to sustain individually, without any cross-subsidization from other classes. The process of detariffing has taken care of this aspect to a great extent. An efficient upfront underwriting would go a long way in addressing several problems associated with health insurance. This would minimize, if not avoid the large scale dissatisfaction about the management of the portfolio by the
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insurers. The service providers, on their part, should make efforts to erase the commonly held belief that they fleece the customers if they have insurance cover. The system can be improved; provided, the insurers, the insured and the service providers jointly put in efforts to remove some of the weaknesses in the existing system.

LACK OF DATA

The lack of health insurance data in India has been cited by many for a long time. While this would have been true three years ago, that is not the case any more. The data does exist and it is of fair quality. It is also amenable to significant types of analysis.

The recently released findings of the IRDA – CII data committee demonstrate this. The committee mainly comprised of professionals from general and life insurance; TPAs and included select representatives from associated fields, such as actuarial, IT, reinsurance, disease management, healthcare and pharmaceutical sector. The findings of this committee were presented at a dissemination workshop on May 9th, 2008.

There is now a clear need for more effective utilization of data analysis in the new competitive regime of pricing where cross subsidy across business lines is less feasible. Proper data analysis is also necessitated by new regulations of IRDA such as IBNR (Incurred but not Reported) estimation and Product Filing Requirements. It is also important to create industry-wide benchmarks to enable an insurer to compare its own performance and rates with industry standards. In light of the current scenario, it is worthwhile to look at how data quality can be enhanced, what type of analysis can be conducted, how industry benchmarks can be developed and to understand the benefits of industry collaboration.
2.13.1 ISSUES OF CONCERN

Age-band to which an insured belongs alone is the current underwriting consideration to quote a premium rate. Life style, hereditary factors and other individualized risk factors do not matter sufficiently to insurers to write this business, as exclusively individualized. Homogeneity of risk group for rating is based on age; and it continues to be so. It has not evolved over the years due to their inability to collect experience data. Risk discrimination within the age group is not made. That is a major issue for insurers. Each insured in the health segment is a unique risk irrespective of his/her age and that is why in health insurance, underwriting and pricing risk factors properly is even more important than in any other segment of business. There are no risk management measures an insurer can possibly suggest on the life style of an insured, nor there can be an audit of what precautionary measures for wellness an insured takes on his own. The point made herein is that careful underwriting has a major impact on expected outcomes; more on this later.

2.14 CRM IN LIFE INSURANCE

Customer Fairness has many connotations depending upon an individual’s values, experience and expectations.

According to U Jawahar Lal (2009), the concept of Treating Customers Fairly is an attempt to align the company’s interest with that of its customers through various cultural and procedural initiatives. TCF is important for a number of reasons but the most compelling reason for pursuing the concept is that it is based on the core business principle of putting customer first by
understanding his needs and expectations. The commercial benefits of treating the customer fairly are not only unequivocal but also exponential. A customer who has been treated fairly is the strongest brand ambassador that a company can have in today’s intensely dynamic and competitive environment.

To treat customer in better manner provides benefits that are compelling for any organization and are in the form of:

- Improved customer loyalty
- Increased customer satisfaction
- Improved customer trust and confidence
- Improved reputation in a highly competitive market
- Improved goodwill
- Increased cross sales
- Positive brand recall

All of the above have a direct and material impact on the well being of an organization through improved profitability, increased shareholder return and reduced risk of regulatory non-compliance.

Though TCF is applicable and relevant in all service industries, its relevance in the financial services industry is unmatched. TCF has long been embedded in the corporate environs of the financial industry in many countries. In UK for example, the Financial Services Authority (FSA), which is the Regulator of the financial services industry, has defined six consumer outcomes, which articulate the concept of TCF. The aim of this initiative is to promote efficient, orderly and fair financial markets which would help customers get a fair deal.
T. R. Ramachandran (2009)\textsuperscript{47} emphasizes that a customer who has been treated fairly is the strongest brand ambassador that a company can have in today’s intensely dynamic and competitive environment.

2.15.1 Simple and Plain Policy Language

Today, the customer has enough choice to take her business elsewhere if she is not given acceptable and fair products and service. Companies must realize that profit comes in two types – good profits and bad profits. One can profit by taking undue advantage of the customer at the time of sale and not being transparent about the product/ pricing. The same customer may unknowingly buy the product, but later will not return to the company for another policy. He may also create poor word-of-mouth leading to more potential customers getting driven away. Good profits on the other hand are sustainable, fair and have the potential to grow in the future. A good brand is built in this way over a period of time. People prefer a brand because of this inherent goodwill built over time and also show greater loyalty.

Rajiv Jamkhedkar (2009)\textsuperscript{48} asserts that people prefer a brand because of the inherent goodwill built over time and also show greater loyalty. The top management of the company has to create the culture where treating customers fairly is instilled in the day-to-day working of the company. This is valid for product design, customer service, claims, and sales practice. The intent, policy and culture of the organization should translate into outcomes that the customer can experience.

2.15 GAPS IN LITERATURE

The review of literature has thrown light on various contemporary issues; it has given different existing issues to think off and identified the various concerns to work upon. The present study aims to bridge this gap in
literature, suggest the suitable policies to grab the existing business potential available in the market and prepare the base for further studies.

**CONCLUSION**

In-depth review of existing literature has highlighted the thought of different scholars on existing issues. Present chapter identified several kind of issues related to various parameters like Customer service, Marketing strategies, Regulatory compliances, Business potential, Product benefits. The gaps in existing literature were identified. There is an immense need to work on existing lacuna in the system and suggest suitable strategies. This review forms the basis of the conceptual framework and premises of the study discussed in Chapter – I.
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