i-notes Newsletter from India's Leading Insurance Broking House
April 2010

Summary

India Insure The risk managers

Message from the Editor

Dear Readers,

Another financial year has come to a close and the final results are awaited. Indications are that the year would see the General insurance industry closing at around Rs. 39000 crores indicating a growth rate of 14.5% and the Life industry at about Rs. 100000 crores which is a growth of around 15%.

This fiscal has seen three new insurers commencing operations and we have also been witnessing the signs of the commencement of hardening of the market. There have been quite a few upheavals with several cases being reported of insurers cancelling health policies in cases where the claims experience was spiralling. Whether this trend continues remains to be seen!

While premium figures are talked about across the industry, not much information is made available about claims. We hence thought it appropriate to put together some information on the claim trends in the general insurance industry and have compiled the trends and claims statistics for the past three years.

In the interview section, we have interacted with corporates, surveyors and insurers regarding their experiences with the way claims are being handled and are thankful to Mr. P C Somani, Executive VP, Supreme Industries; Mr. Kaushal K Mishra, Executive VP – Business Operations, TATA AIG; Mr. Nitin Deo, Head – Claims, Future Generali and Mr. Rajan Srivatsan, Director, Professional Surveyors & Loss Adjusters Private Limited.

This year marks a decade of liberalisation of the industry and the issues associated with the initial opening up have been handled with due maturity by all players. We now look forward with anticipation as to what the second decade will have to offer. Mergers, acquisitions, change of partners, withdrawal from the market, increased foreign participation; this decade will probably see it all.

Wishing you all the best for the new fiscal!

V Ramakrishna
Editor – *i-notes* & Chairman – India Insure

Claim Trends in the Non-Life Insurance Industry

As we look across the insurance industry, claims management continues to be a major area of interest and concern since it has a profound impact on customer satisfaction and an equally profound impact on the insurer's bottom line. After all, the raison d'être of any insurance company is to pay claims. Insurers are constantly looking for ways to stop claims leakage and improve the overall claims experience for the policyholders. But off late, the unshakable obsession of top-line growth is causing insurers to accept all risks to boost market share and then indulge in 'claims underwriting'. Unfortunately, we seem to be losing sight of the fact that claims are the shop window for the industry and we are judged by our customers on our claims record. In today's marketplace the need to balance underwriting with claims and find ways to respond to change through transformation, is essential for survival.

During the last five years, the non-life insurance industry in India has experienced a stretch of impressive growth – growing from Rs. 18095 crs of gross premium in 2004-05 to Rs. 32712 crs in 2008-09. Unfortunately in a crowded insurance marketplace where supply exceeds demand, the continual entry of new players coupled with the intense competition sparked off by detariffication is causing premiums to fall year-after-year whereas claims ratios are amplifying. Underwriting performance in the industry has been under increasing pressure on account of rising claims and the consequent underwriting deficit. While the customer no doubt has benefited, the impact on the insurers has been less promising so far.

In this article, we highlight and analyze the claim trends across the non-life industry in the past 3 years.

Report Card on Claims

Claims Ratio: Co-wise for last 3 years*

Insurer	Claims Ratio		
	2008-09	2007-08	2006-07
New India	89%	87%	80%
Oriental	100%	90%	88%
National	99%	94%	87%
United India	79%	93%	90%
Royal Sundaram	69%	68%	61%
Bajaj	72%	67%	66%
Tata AIG	61%	58%	54%
Reliance	77%	78%	71%
Iffco Tokio	83%	79%	73%
ICICI	85%	78%	76%
Cholamandalam	72%	66%	56%
HDFC Ergo	81%	76%	57%

* Source: IRDA Annual Report

Earned Premium (Net)[1] & Incurred Claims (Net)[2]: Dept-wise for the last 3 years

Fire Portfolio

- In 2008-09, the earned premium under fire insurance declined by Rs. 69 crs compared to 2007-08. The incurred claims on the other hand rose by Rs. 116 crs with the claims ratio[3] shooting up to 76% from 69%. Among all the players, Oriental recorded the highest claims ratio at 115%, followed by ICICI at 96%.
- In 2007-08, the earned premium under fire insurance rose by Rs. 66 crs compared to 2006-07. Segregation of the PSU

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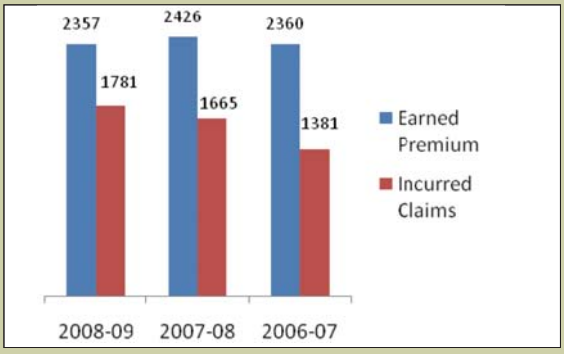
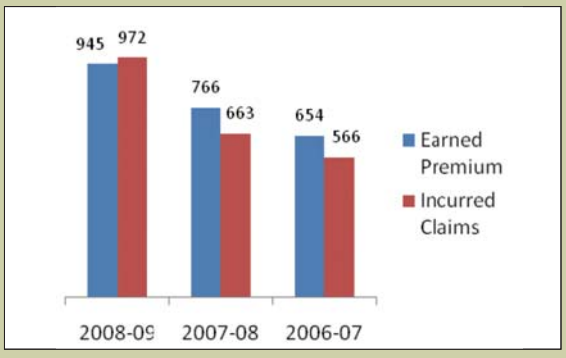


& Private sector reveals that the earned premium of the PSU's had in fact declined by 20 crs while the private players in contrast grew their earned premium by 86 crs.

- The total incurred claims during the same period rose by Rs. 284 crs, the claims outstripping the premiums by Rs. 218 crs. While the incurred claims of the PSU's rose by 220 crs, surprisingly the incurred claims of the private players rose by only 64 crs. Among all the players, Oriental recorded the highest claims ratio at 96%, followed by National at 84%.

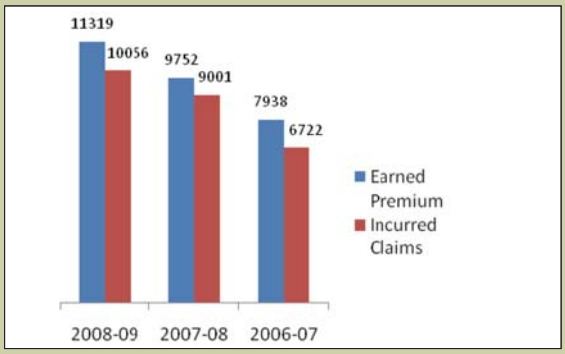
Marine Portfolio

- A look at the past 3 years reveals that marine premiums rose by 17% during FY 08 and during FY 09, it rose by 23%.
- While the premiums for the FY 06 and 07 hovered at 600-650 cr levels registering a CAGR of around 3%, the incurred claims on the other hand increased by around 17% during the same period.
- In FY 09, the incurred claims shot up by 47%. The claims ratio for FY 09 is at 103% - by far the highest in the past 5 years and should be a matter of concern. ICICI recorded the highest claims ratio of 202% followed by Reliance at 122% and New India at 120%. In fact all the players except two have their claims ratios above 80%.



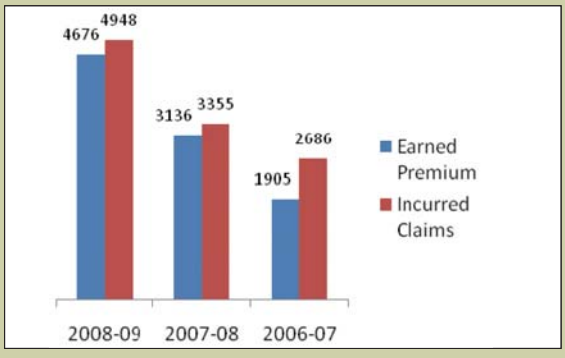
Motor Portfolio

- In 2008-09, the earned premium under motor portfolio grew by Rs. 1568 cr i.e. 16% compared to 2007-08. The earned premium for the PSU's grew by Rs. 396 cr (6.5%) while for the private players it grew by Rs. 1171 crs (32%) thus highlighting the fact that private players are now more inclined towards the motor business. Bajaj, Reliance and Iffco Tokio have been the major contributors towards the acretion of 1171 crs.



- The incurred claims during the same period have gone up by Rs. 1054 crs i.e. 12%. For the PSU's, it has gone up by Rs. 37 crs (< 1%) while for their private counterparts, it has gone up by Rs. 1017 crs (38%). All the PSU's except for United have claims ratio > 100%. The rising claims ratio of the private players which started as a trickle (64% in FY 07) is now spreading like a rash (76% in FY 09).
- In 2007-08, the earned premium under motor portfolio grew by Rs. 1814 crs i.e. 23% compared to 2006-07. For the private players, the earned premium grew by Rs. 1557 crs (73%) as against a growth of less than 5% (Rs. 257 crs) for the PSU's.
- The incurred claims during the same period have gone up by an alarming 2279 crs (34%). For the PSU's, the incurred claims are up by Rs. 994 crs with the claims ratios up by 13% to 105%. For the private players, it has gone up by Rs. 1284 crs with the claims ratio up by 8% to 72%.

Health Portfolio



2008-09

- In 2008-09, the earned premium under the health portfolio grew by Rs. 1540 cr i.e. 49% compared to 2007-08. The earned premium for the PSU's grew by Rs. 919 cr (42%) while for the private players it grew by Rs. 621 crs (65%). ICICI & Reliance between the two of them have contributed over Rs. 418 cr to the private sector EP of Rs. 621 cr.

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Claim Trends in the Non-Life Insurance Industry..... Contd. # 2

- The incurred claims during the same period have gone up by Rs. 1593 cr. While the overall claims ratio in this portfolio has noticed a declining trend over the past 3 years, insurers are still deep in the red.
- For the PSU's, the incurred claims has gone up by 1164 cr (outstripping the EP by 245 cr), while for the private players it has gone up by 429 cr. All the PSU's have claims ratio > 100% with Oriental leading the lot at 137%. While United & National could bring down their claims ratio marginally when compared to the previous year, the claims ratio of New India & Oriental has gone up.
- Among the private players, ITGI has the highest claims ratio at 122%, followed closely by Chola (109%) and HDFC Ergo (101%).

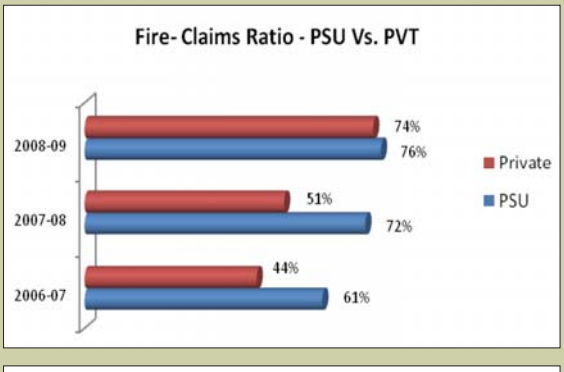
2007-08

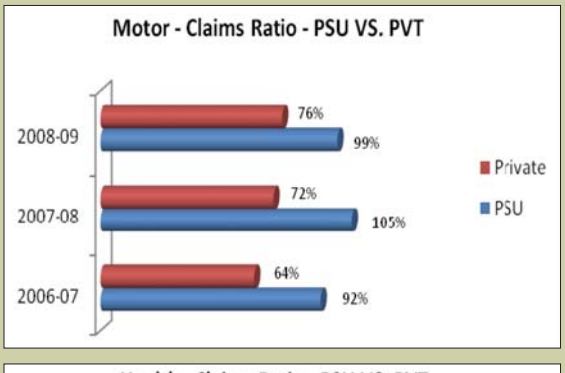
- In 2007-08, the earned premium under health portfolio grew by Rs. 1231 cr i.e. 65%. For PSU's, it grew by 858 cr out of which New India alone contributed 514 cr. The private players grew their EP by 372 cr.
- The incurred claims during this period have startlingly gone up by only 669 cr. For the PSU's, eventhough the incurred claims are up by Rs. 366 crs, the claims ratio has come down to 112% from the earlier 158%. One reason for this drastic fall in claims ratio could be the rise in health insurance premium especially for the retail segment. The incurred claims of the private players went up by 303 cr; and claims ratio has come down to 95% from the earlier 103%.

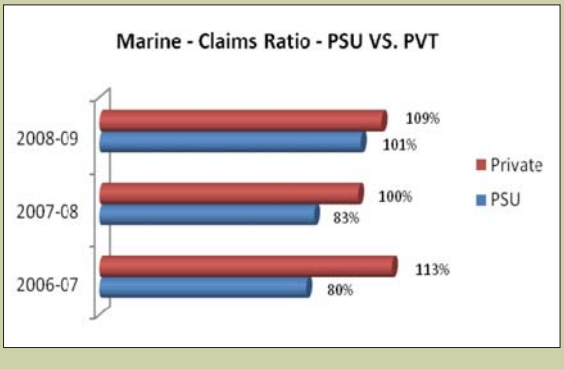
Percentage Share of Premium & Claim

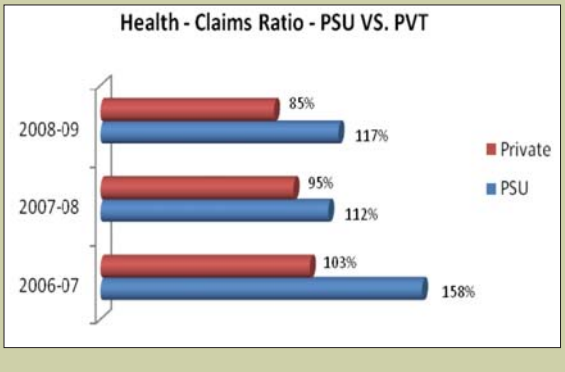
	2008-09	2007-08	2006-07
FIRE			
Share of Premium	10%	13%	15%
Share of Claim	9%	10%	11%
Claims Ratio	76%	69%	59%
MARINE			
Share of Premium	4%	4%	4%
Share of Claim	5%	4%	4%
Claims Ratio	103%	87%	87%
MOTOR			
Share of Premium	50%	51%	49%
Share of Claim	51%	55%	52%
Claims Ratio	89%	92%	85%
HEALTH			
Share of Premium	21%	16%	12%
Share of Claim	25%	20%	21%
Claims Ratio	106%	107%	141%
OTHERS			
Share of Premium	15%	17%	20%
Share of Claim	10%	10%	13%
Claims Ratio	54%	53%	53%

Claims Ratio: Dept wise – PSU VS. Private









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In the interview section this issue, we have three different view points on the topic of claims. The first is the Insurer view point, where we have *Mr. Nitin Deo, Head- Claims, Future Generali and Mr. Kaushal K Mishra, Executive VP, TATA-AIG* who talk about improving transparency and information sharing in the claims process. They also comment on how their companies are able to distinguish themselves and provide superior claims service to their customers.

Secondly, we have *Mr. Rajan Srivatsan*, *Director, Professional Surveyors & Loss Adjusters Private Limited* who discusses the current challenges in the area of loss adjusting & claims.

Thirdly, we have the Corporate view where *Mr. P C Somani, Executive VP, Supreme Industries* shares his experience on how their company's claims were handled by the insurer and their suggestions to improve the quality of claims servicing.

Insurers

Claims management has a profound impact on an insurer's bottom line and an equally profound impact on customer satisfaction. As important as it is, however, many insurers struggle to optimize this activity resulting in increased costs, leakage and poor customer service. What do you think are the reasons for this?

Mr. Nitin Deo: While claims servicing is a much professed philosophy for the insurance companies, for all practical purposes it is taken for granted. In the initial years, the main focus of the companies is business development. They are more intent on capturing the market share than in having satisfied customers. At the beginning, even the normal controls on claims costs are ignored in the race to grab the market share, which eventually lead to higher costs. There is always a time lag between the built up of claims volume vis-à-vis premium. The failure to anticipate this increase in claims volume and corresponding service resources is what ultimately leads to poor service delivery.

Mr. Kaushal K Mishra: Professional claims management ensures that while delivering claims service the insurance company fulfils customer's service expectation, learns more about the customer and the risk underwritten to develop a better product, reduce cost of service, build a lasting relationship and prevent avoidable leakages through fraud management. In this competitive environment customer loyalty is fragile, hence a well managed claim service ensures high customer retention and facilitates in brining in new customer through customer / intermediary referrals.

Different insurers attach differing importance to Claims Function and its position within Company is determined by the worldview/ culture of the company. On one extreme are companies, which attach a lot of importance to independence of Claims and believe in keeping it independent of sales pressure, so as to maintain integrity and fairness in settlement. On the other extreme would be companies which do not attach importance to claims and make them answerable to the sales/ underwriting teams. There would be still more companies in between the two, who would look upon it as a 'necessary evil', and make it part of Operations.

I find that majority of general insurers tend to handle claim as an isolated process, rather than manage, optimize and integrate claims service with the functioning of entire insurance company. Claims management has evolved into a sophisticated ecosystem with a complete lifecycle of its own, which has to comply with a host of mandates and regulations. Claim service is no longer just a means to fulfill contractual obligations, effective claims management have become a key battleground for competitive differentiation. To build an integrated claims management requires commitment from Insurer's top management to deploy substantial capital and time to ensure high quality human resource in claims department, periodic professional training and optimum technology solutions.

Point is companies need to view the function as one needing 'specialized' as well as 'delicate' handling. Many err and result is a confused, irritated & dissatisfied customer, who views not one company but the whole sector negatively.

The reasons can be many, but unless Underwriting, Sales and Claims operate in tandem, claims management will always remain an 'Oasis of Excellence' in some companies and 'Reasons for Failure' in some other companies.

From the customer's perspective; claims management is a slow, unclear process with practically no transparency. What do you believe can be done to bring in more transparency and information sharing in the claims process?

ND: It is important that the customer is adequately educated about the coverages and exclusions under a policy. This must be done at the time of selling the policy. Thus, the main responsibility of educating the customer lies with the party who sells the policy to the customer. If the broker / agent / company owns the customer, it is necessary for them to educate the customer on the processes and time lines. An insurance company, for its part, must ensure that every insured is briefed properly about the claims process at the time the claim is reported. Information on time lines for every activity is to be shared to avoid unreasonable expectations. Updates by optimum use of technology about the various stages of the claim will go a long way in keeping the process transparent and avoiding unpleasant surprises for the customer.

A major point of conflict is the overcharging by the service providers such as workshops and hospitals. In the ensuing stand off between the insurance company and the service provider, it is the customer who faces the problems and delays and feels that he's been given a raw deal. The insurance companies need to look at this a little more seriously and make an effort to sort out the issue in order to have happier and more satisfied customers.

KK: Insurance product selling process entails focussing the customer's attention on various product features and price competitiveness. The selling process rarely educates the customer regarding the basic claim process. As a result at the

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Report Card - February 2010

Gross premium underwritten by non life industry for and up to the month of February 2010* (Rs. In crores)

INSURER	FEBRUARY		GROWTH OVER THE SAME PERIOD OF PREVIOUS YEAR	APRIL - FEBRUARY		GROWTH OVER THE SAME PERIOD OF PREVIOUS YEAR
	2009-10	2008-09		2009-10	2008-09	
New India	470	420	11.83%	5428	4987	8.85%
United India	384	316	21.43%	4551	3810	19.45%
Oriental	360	309	16.26%	4139	3575	15.76%
National	400	309	29.35%	4104	3868	6.11%
ICICI-lombard	273	216	26.28%	3003	3256	-7.77%
Bajaj Allianz	213	193	10.38%	2245	2408	-6.73%
Reliance General	137	141	-2.37%	1847	1777	3.96%
IFFCO-Tokio	108	96	12.40%	1337	1258	6.29%
HDFC ERGO	69	30	128.07%	823	298	175.64%
Royal Sundaram	79	65	20.75%	820	728	12.68%
Tata-AIG	76	63	19.82%	814	813	0.07%
Cholamandalam	64	56	14.41%	724	644	12.40%
Shriram General	52	25	102.52%	358	107	233.58%
Future Generali	35	20	71.59%	343	170	100.95%
Bharti AXA	32	6	399.53%	244	21	1076.76%
Universal Sompo	20	7	174.49%	155	19	702.17%
Raheja QBE	0	0	0	1	0	0
PRIVATE TOTAL	**1158**	**920**	**25.84%**	**12714**	**11499**	**10.57%**
PUBLIC TOTAL	**1614**	**1355**	**19.08%**	**18222**	**16240**	**12.21%**
GRAND TOTAL	**2772**	**2275**	**21.81%**	**30937**	**27739**	**11.53%**
SPECIALISED INSTITUTIONS:						
1.Credit Insurance						
ECGC	71	66	6.93%	732	666	9.94%
2.Health Insurance						
Star Health	134	10	1228.78%	921	494	86.25%
Apollo Munich	9	5	99.79%	100	43	134.45%
Health Total	**144**	**15**	**869.45%**	**1021**	**537**	**90.09%**
3.Agriculture Insurance						
AIC	162	82	98.85%	1422	737	93.02%

* Source : IRDA

Observations: Performance for Apr- Feb 2010 Period

- The industry (incl stand alone health insurers) have collected premiums of Rs.31958 crores recording a growth rate of 13.02% in Apr-Feb 2010 compared to Rs. 28276 crores during the same period last year.
- The private players have registered a growth of 10.57% during this period compared to 12.86% during the same period last year.
- The PSU's have registered a growth rate of 12.21% during this period compared to last year's 6.20%.
- The accretion achieved by the PSU's during this period is Rs.1982 crores; the private players: Rs.1215 crores and stand-alone health insurers: Rs.484 crores towards the overall market accretion of Rs.3681 crore.
- The major contributors for the performance in the period Apr- Feb10 have been United India with an accretion of 741 crores, Oriental with an accretion of 564 crores, HDFC ERGO General with an accretion of 524 crores and New India with an accretion of 441 crores.
- ICICI Lombard (-7.77%) & Bajaj Allianz (-6.73%) have recorded negative growth during this period.

News TitBits

After hefty discounts, general insurers see rise in premium rates

Source: The Hindu Business Line

Having witnessed a steep decline in premium rates in a highly competitive environment after the detariffing of rates in 2007, the general insurance companies are now looking at arresting the exorbitant discounts in rates. The year 2009, industry experts say, had marked the beginning of a certain degree of stabilisation in general insurance premium rates. "The trend of further lowering of premium rates has been arrested in 2009 and we may see certain degrees of firming of the rates now," Mr N.S.R.C. Prasad, the CMD of National Insurance Company (NIC), said.

Tata AIG's cover for pollution damage

Source: The Hindu Business Line

Tata AIG General Insurance has launched a pollution legal liability insurance to insure companies in the field of chemicals, petrochemicals, energy and construction when they cause damage to the environment. The policy provides third party coverage for bodily injury and property damage, first party coverage for on-site clean up costs and makes no distinction between sudden and gradual events causing pollution, the company said in a press release.

Regulator unhappy with TPA's

Source: DNA

"The TPA system remains a concern as they are not performing as per customer satisfaction," the Insurance Regulatory Development Authority (IRDA) Chairman, J Hari Narayan said, adding that despite the promises, the end users, particularly those who have availed of cashless medical facilities, are facing the brunt of inefficient services. "The way the TPAs are running their business has posed a threat to the entire medical insurance sector. Almost 80% of the health insurance industry is facing a threat due to the functioning of TPAs," he said.

26/11 victims' families go to apex court over hotel security

Source: Sify

Four Mumbaikars who lost their family members in 26/11 have approached the Supreme Court seeking direction for enactment of laws for adequate security measures in luxury hotels and insurance cover for hotel guests falling victim to terror attacks. The Supreme Court sought the government's stand on the lawsuit.

IRDA wants SEBI to keep off Ulips

Source: Livemint

India's insurance and stock market regulators are engaged in a turf war over the regulation of Ulips - insurance products that mimic mutual funds. SEBI fired the first salvo last month when it sent a show-cause notice to all life insurance companies, including state-owned LIC, asking them to explain why they hadn't taken its prior approval before launching Ulips. IRDA, hit back saying- "Ulips, globally, are managed by insurance regulators, and under no circumstance will we let Ulips to be taken over by Sebi," R. Kannan, a member of Irda, said in an interview.

Readers Speak - *Insurance Broker Rating*

Your insurance broker today can give you more options than the cocktails available at the bar. In less than a decade, the number of insurance brokers has increased manifold. Against just 40 brokers in 2003, today there are around 275 insurance brokers operating in India. And, the party is still on with more and more adding to the numbers.

Not surprising then that the queue of brokers wooing a customer is increasing and selecting the best insurance broker is becoming one of the most difficult tasks for a client. Each broker is different, with different strengths and weaknesses. You get to know how good your broker is – only after policy placement. And, if you end up choosing the wrong one, you are stuck for a year. Thus, selecting the best one is no easy task.

Do you think your task will become simpler if the regulator or any independent rating agency rates the insurance brokers on various parameters like understanding of the market, technical expertise, responsiveness to customer needs, business retention, professional standards etc..?

What's your take? Will the rating of insurance brokers make life easier for the customer at the time of selection? Will customer go by the rating or again only by the lowest price? Who should be entrusted with this task of rating?

Your opinion is solicited!

Please send your responses in 200-300 words to knowledge@indiainsure.com

In the last issue of inotes, we had asked

"Has the quality of claims service improved over the years with technological advances or has it worsened? If so, what are the reasons for improvement / causes of the problems? How can claims handling be a better experience for both, the customer and the insurer?"

Below are some of the responses we received

Mr. Srinivasan Ramabadran, General Manager- General Alliance Insurance Ltd says

Disputes generally arise on account of the following:

- Understanding/mis-understanding the scope of cover
- Policy exclusions
- Proximate cause
- Properties insured or not. Eg -Compound wall and fence not being declared separately.
- Under-insurance

Unless and until the clients get a clear picture and understanding of the above at the time of insurance, we can continue to have disputes even after another couple of decades. It is the duty of the marketing personnel and the underwriters to ensure that the clients get what they want to insure. Automation of claims processing can to some extent speed up the claims, but the understanding the intricacies of the particular claim needs manual intervention and a positive approach by the claims team.

Claims Case Study: *The existence of fire*

Background:

M/s ABC Industries Limited is into the manufacture of fertilizers and pesticides. The plant is located in Chembur. Insured had taken Insurance Policies in respect of its plant- one policy was a fire policy and the other was a fire loss of profits policy.

Claim Details:

On 18.4.2002 at about 2.45 p.m. there was a short circuiting in the main switch board installed in the sub-station receiving electricity from the State Electricity Board, which resulted in a flashover producing over currents. The flashover and over currents generated excessive heat. The paint on the panel board was charred by this excessive heat producing smoke and soot and the partition of the adjoining feeder developed a hole. The smoke / soot along with the ionized air travelled to the generator compartment where also there was short circuiting and the generator power also tripped. As a result, the entire electric supply to the plant stopped and due to the stoppage of electric supply, the supply of water/steam to the waste heat boiler by the flue gases at high temperature continued to be fed into the boiler, which resulted in damage to the boiler.

As a result the complainant approached the Insurance Company informing it about the accident and making its claim. The claimant made two claims:

i. Rs.1,57,70,850/- for material loss due to the damage to the boiler and other equipments and

ii. Rs.14,23,63,000/- in respect of loss of profit for the period the plant remained closed.

Surveyors were appointed who submitted their report and the appellant-Insurance Company rejected the claim. Hence, the petition before the National Commission.

Mr. S. Sampath Kumar, Insurer says

Though it is seldom the aim of any Insurer to avoid payment by any unjust means, the insured when becomes a claimant is not very confident and sometimes resorts to withholding or diluting information.

Even after so many years, people get constrained by jargons and varied interpretations. If you take the example of Standard Fire & Special perils policy, it appears very lucid with the perils insured clearly listed out. But even here, there occurs disputes at the time of a claim. Perhaps more simplification is required with the exclusions and the terms and conditions and not just the coverage.

Again, as all of us know that Fire Policy does cover 'wind and water perils' under STFI. Here all Insurers and those in trade refer to Beaufort scale. To the common man, property getting damaged by forces of nature would entail a claim but to his bewilderment, he would then find that storm is wind at more 55 mph and again establishing this sometimes becomes herculean, though many Insurers are open to circumstantial evidence. I personally feel that the quality of claim service has increased but the expectations in the modern world are so high and at times we suffer to grapple.

{Views expressed are personal & does not reflect the views of the Company}

The Issue:

Learned counsel for the Insurer submitted that the loss to the boiler and to the equipments did not occur due to any fire, but by the stoppage of electric supply due to short circuiting in the switch board. The proximate cause has to be seen for settling an insurance claim, which in the present case, was the thermal shock caused due to stoppage of electricity. He argued that for a claim relating to fire insurance policy to succeed, it is necessary that there must be a fire in the first place. In the absence of fire, the claim cannot succeed. In the present case (1) there was no fire and (2) in any case it was not the proximate cause of the damage. Hence, the claim of damages did not fall under the cover of the Insurance Policy.

Therefore the Commission now had to first determine whether there was a fire. Admittedly there was a short circuit which caused a flashover.

Wikipedia defines flashover as follows :

"A flashover is the near simultaneous ignition of all combustible material in an enclosed area. When certain materials are heated they undergo thermal decomposition and release flammable gases. Flashover occurs when the majority of surface in a space is heated to the auto-ignition temperature of the flammable gases."

In this connection, it is admitted that the short circuit in the main switch board caused a flashover. The 1st surveyor in his report has observed: "Flashover, can be defined as a phenomenon of a developing fire (or radiant heat source) radiant energy at wall and ceiling surfaces within a compartment..... In the present case, the paint had burnt due to the said flashover..... Such high energy levels, would undoubtedly, have resulted in a fire, causing melting of the panel board....."

The other surveyor has stated that "Fire of such a short duration cannot be called a `sustained fire' as contemplated under the policy".

Court opined that the duration of the fire is not relevant. As long as there is a fire which caused the damage, the claim is maintainable, even if the fire is for a fraction of a second. The term 'Fire' in the Fire Policy is not qualified by the word 'sustained'. Hence repudiation of the policy on the ground that there was no 'sustained fire' in court's opinion is not justified.

The next question was whether the flashover and fire was the proximate cause of the damage in question.

To understand this, it necessary to go through the chain of events. After going through the sequence of events once again, the Commission concluded that the flashover was the proximate cause of damage.

The Commission also referred to the Insurer's written submission before the National Commission where in it has been admitted that there was a flashover and fire. ".....Due to this flash over and over currents excessive heat energy was generated which resulted in the evolution of marginal fire....."

The Outcome:

It was the flashover/fire which started the chain of events which resulted in the damage. It is evident from the chain of events that the fire was the efficient and active cause of the damage. Had the fire not occurred, the damage also would not have occurred and there was no intervening agency which was an independent source of the damage.

Hence the court did not agree with the conclusion of the Insurer that the fire was not the cause of damage to the machinery of the claimant. The Commission hence allowed the claim.

News TitBits

Life insurance policies could soon become paperless

Source: Economic Times

Life insurance policy holders may not be required to keep paper records of their policies once the plan for digitalisation of the sector that is being worked on the Life Insurance Council is approved by the regulator IRDA. "The proposal will be finalized in a month. We are examining the issue. The current system involves a lot of logistics," S B Mathur, the council's secretary general said.

Corporation Bank plans non-life insurance foray

Source: Financial Chronicle

The Mangalore-based Corporation Bank is planning to foray into the general insurance domain within a year or two. The bank has drawn up plans for the same and may start scouting for partners over next few months.

Union Budget 2010: Health insurance costs set to go up

Source: Economic Times

Health insurance costs are set to soar with the government deciding to impose service tax on payments made by insurance companies to hospitals in settlement of claims where policyholders had received cashless service. Each year the non-life industry pays around Rs 6,000 cr by way of claims to the healthcare sector. Over half of the payments are by way of settlement of claims for cashless treatment. "The proposal to impose service tax on payments made to hospitals under health insurance schemes, which could push up costs for end customers." Bhargav Dasgupta, MD & CEO, ICICI Lombard GIC.

IRDA whip against pyramid schemes

Source: Economic Times

In a bid to crackdown on pyramid schemes, the insurance regulator has barred companies that do not have a substantial customer base of their own from becoming corporate agents. The regulator has also said apart from RBI-regulated finance companies, any entity seeking a corporate agency licence should have a turnover, assets or income of at least Rs 15 crore.

Some of the large Claims in India in the last 5 years*

S.No.	Name of the Event	Date of Loss	Estimate of Loss (in INR mn)
1	IOCL, Jaipur fire loss	29.10.2009	1400
2	Flood Loss in AP & Karnataka	Oct 2009	1000
3	Damage to the Gas Turbine of BHEL due to collapse of a road bridge in Gujarat	08.08.2009	1500
4	Haldia Petro Chemicals Ltd. – Fire loss	01.07.2009	3100
5	Taj Hotels Terrorist attack, Mumbai	26.11.2008	5000
6	Surat- Gujarat Floods	Aug 2006	10000
7	SJVN flood loss	Sep 2005	3150
8	ONGC- BHN fire accident	27.07.2005	17000
9	Mumbai Floods	26.07.2005	26000

* Source: Insurers & Media reports

What should insurers be worrying about?

o Impact of Climate Change on Claims

The insurance sector in particular is experiencing one of the most direct impacts of climate change; it is estimated that around 1/3rd of all overall insurance claims are from weather related natural disasters. The impact of climate change on the general insurance industry is likely to be far reaching and insurers will encounter a number of new types of claims. In the recent past - cyclones, floods, landslides, bush fires & other major catastrophes around the world have heavily impacted insurers' balance sheets. Apart from the direct impact of weather related catastrophes, climate change may also result in increased liability claims. In the US, for example, a number of court cases have been brought seeking damages against companies that have emitted large amounts of carbon dioxide & other greenhouse gases.

o Controlling Claims Leakage

Statistics reveal that insurance frauds eat away up to seven percent of gross premium. Frauds take a variety of forms - some are completely false claims and the supposed claim incident never occurred; some are opportunistic - a genuine claim incident has occurred but the claimant has deliberately overstated the extent of the losses incurred and some relate to deliberate (i.e. non-accidental) acts like setting an office on fire, especially businesses that are in financial ill health. The motor insurance market is also seeing an increase in staged accidents or prearranged crashes, usually involving several people from the injured person to the driver, lawyer and doctor. Non-life insurers need to intensify their efforts to identify and weed out such fraudulent claims. Nevertheless, they have a tough job in hand because majority of the insured in India do not regard defrauding insurers as criminally or even morally wrong.

Another type of claims leakage happens when the insured does not act uninsured and fails to take reasonable care to prevent or minimize a loss. The policy conditions make it incumbent upon the insured to act as a prudent party in minimizing all damages. But many a times, this statutory duty is not remembered exposing the insured property to loss which could otherwise have been avoided, had the insured acted diligently.

o Poor Underwriting Performance

The detariffing regime as well as the fierce competition has led to a virtual price war resulting in an adverse impact on the profitability of insurance companies. The trends in policy renewal this year indicate nil or marginal increase in premium rates. While Fire and Motor segments continue to show resistance towards premium revisions, the Health segment shows a slight northward movement.

After a prolonged soft market and high levels of underwriting losses, premium rates and underwriting results need to improve significantly to achieve widespread profitability. Insurers will also have to improve and consolidate their processes for data mining. Some parts of the insurance industry have made considerable efforts to collect & analyze data. The rest of the industry could benefit from following suit. Collaboration between the insurance industry participants will be all the more important. As increasingly reliable, quantitative information becomes available, it will propel the scientific pricing of insurance products.

o The State of Claims Today

The biggest challenge of insurance - an intangible product - is that the only time it is really tested is if there is a claim. And claims handling is one of the main areas giving rise to complaints from consumers of insurance products. This is perhaps not surprising given that when your customers make a claim they are likely to be in some form of distress and more sensitive to things not going the way they feel they should.

After the initial sale of the policy, the highest volume of customer interactions occurs during claims processing and the poor settlement of a claim may turn the customer and insurer into adversaries. The minute something goes wrong in a claim, the insurer is pretty much done – there is no second chance – the customer is going to switch to somebody else. After price, a bad claims experience is generally the most common reason for policyholders to shift to another insurance carrier.

Insurers and claims handlers often only see the world through their glasses, but the broader customer dynamic requires a different viewpoint. The trend of accepting all risks in order to enhance the business portfolio; and then indulge in 'claims underwriting' should be avoided. Incidentally, while insurance companies grumble about the high incidence of false claims, customers complain about the difficulties in getting legitimate claims processed.

(Contd... 09)

inotes Newsletter from India's Leading Insurance Broking House
April 2010

Claim Trends in the Non-Life Insurance Industry .. Contd. # 8

Interview –*Claims : Three Dimensional View...*Contd. # 4

Historically, one of the most unpleasant features of claims handling, from the customer's perspective, has been the opacity of the process. Customers are frustrated with the length of time and lack of communication involved in the claims process. Insurers have a huge opportunity to improve the speed, accuracy and overall quality of customer service provided by their claims handlers by embracing new technology.

Technology provides a better means of crafting a claims environment that can deliver the level of speed, quality of service and fairness that customers increasingly expect. But to be effective, the high-tech element of claims service must go hand in hand with a high-touch approach. Technology has to be embraced as a facilitator to help us do our jobs better – allowing us to spend more time on the human element of the business – not as a replacement to the discourse that is so fundamental.

Repositioning Claims in Non-life Insurance

A close look at claims reveals a direct correlation between the claims experience and profitable growth. A positive claims experience can have a strong influence on customer loyalty. Loyal customers are not only less likely to shop with competitors, but are also less likely to defect based on price alone. The result is increased retention, renewals and referrals, all of which contribute directly to the bottom line.

As important as it is, however, many insurers struggle to optimize the claims activity. Insurers should recognize that investing in claims management can yield three kinds of returns: lower processing costs, reduced payouts and greater customer satisfaction—and the trade-offs among these benefits are inevitable.

There is an urgent industry need to re-energize claims handling and claims management strategies to enable us to keep more promises than we break, which in turn will enhance the industry's image and bottom line growth. Like chronic alcoholics, we need to get beyond the denial stage, get focused on the fact that we are in the business of creating positive feelings and find ways of uncomplicating our complicated business practices.

Today the critical challenge for insurers is to continue to provide a differentiated claims service while significantly improving the bottom line through improved customer retention and reduced claims outflow.

Terminology

[1]**Net Premiums Earned:** The net premiums written* of an insurer relating to that portion of the term of its insurance policies which fall within a given period.

***Net Premiums Written or Net Premiums:** The total gross premiums written by an insurer for a given period less premiums ceded to reinsurers during such period.

[2]**Claims Incurred:** The aggregate of all claims paid during an accounting period adjusted by the change in claims reserve for that accounting period together with the related claim expenses.

[3]**Claims Ratio:** Claims incurred, expressed as a percentage of net premiums earned.

time of claim the customers are made to fend for themselves. Insurance product selling & distribution process must give due importance to this aspect of educating the customer regarding claim process. Insurer should also set up multiple channels through which a customer can approach the company to intimate a claim. During the first claim related interaction the customer should be informed comprehensively on documentation, turn around times, customers responsibilities, and grievance resolution. The customer should also be provided with latest claim status either through country wide toll free access or internet. Employees and claim service providers should also be sensitized about the difficulties a customer goes through upon happening of a loss.

However, most customers – whether retail or corporate – are unclear about what documents are needed and why they are needed. There is also an unrealistic expectation built in the minds of customers that once a policy is bought, they are automatically entitled to claim. The customers need to be educated that claim settlement is not like going to an ATM, putting in card and taking money out. I sincerely urge Agents and Brokers that they should also educate / request CUSTOMERS to read the Policy at least once!

On the other hand, companies need to improve processing of claims to bring in more standardization in handling, segmentation of claims, better IT systems so that bulk of the claims are paid quickly with reasonable level of documentation. Regular sharing of information on claims progress, explanation of the decision – whether to reject or to pay and, if paid, how much is being paid – will take away significant dissatisfaction from customers' mind.

What are some of the current challenges in the loss adjusting and claims areas?

ND: In most cases, it is the surveyor/loss assessor who has the final say in a claim cycle. Naturally, he plays a very important role in the smooth finalisation of the loss. The profession of the surveyor, however, is losing its charm and it is getting more difficult by the day to find new good & knowledgeable surveyors opting for this profession. Technology is ever changing and the need of the hour is to have surveyors who can keep pace with this change. Salvage disposal and its adequate realisation are areas of concern. Poorly drafted policies and vague usage of terms for coverage add to the problems at the time of adjustment of the claims.

KK: As in any industry, General Insurance will also continue to be burdened with the question of quality and quantity and there are no straight line answers to mitigate both challenges. Scalability of operation, scarcity of seasoned claims professional, and managing customer expectation are some of current challenges.

With top line growth and geographical expansion of business, claims volume and complexity tend to rise in tandem. Though IT enabled claim system have improved productivity but insurer do need claims specialist to service high volume; high complexity claims as per expectations of customer. Presently Indian insurance industry is facing a severe crunch of seasoned claim

(Contd... 10)

staff. With new companies coming up at regular interval retaining these claims specialist at reasonable cost remains a big challenge.

Talent in insurance claim survey and loss adjusting is not getting replenished. Present crop of engineers and CA are not interested to join this profession. Within next few years there may be a crisis if something is not done urgently to address the issue of paucity of professional and effective Insurance surveyors in India.

With increasing numbers are also coupled with wider geographical reach. As companies spread more into hinterland/ rural areas; challenges of settling claims & meeting Turn Around Time TATs are becoming more pronounced.

With today's "now" society, expectations are steeply rising, and increasingly shaped by industries outside of insurance, such as banking, hospitality and retail sectors. Consumer Forum and courts are coming down heavily on insurer for delayed response and denials. More than ever before, the result of a claim settlement no longer represents merely the satisfaction level of a single claimant. Individual experiences are influencing public perception of carriers through internet blogs (like www.mouthshut.com) and discussion groups, creating a vivid customer satisfaction experience. As these tools have gained in popularity, in part due to their acceptance as open and honest forums, so has their sphere of influence.

What is the strategic opportunity that you see in the claims area? How does your company differentiate itself from its competitors in this area?

ND: Controlling costs without compromising or hindering the claims process is a balancing exercise. A robust process needs to be in place to cope with this aspect. Insurance is called people's business. We are aware that a lot of emphasis is laid on the process, making the whole experience uninspiring for the customer. We have made it a point that for every claim, it is necessary that the appointed assessor speaks to the customer with empathy, and tries to take the pain out of the trauma that the customer has gone through. We believe in the philosophy, "Think Global but Act Local". Though the Indian mindset is changing, we still feel a lot more re-assured if we talk to the concerned person, rather than put up our queries on the internet. Further, while the processes are important, the person who carries out the process is even more crucial. They have the power to change the whole experience for the customer by being really interested in it, instead of treating it as routine or mundane job. Every claim is an opportunity of building a life long relationship with the customer. As such, every claim is important because building a reputation in claims is a slow and tiring process. We believe that technology, apart from adding convenience, is indispensible for increasing the productivity and making the processes robust. Our policy is to front load the claims i.e. early investigation, early decision making and early settlement of the claims in order to churn out smarter TATs. We would not like to over promise or under deliver. We are sure that with this approach, we will make our mark in claims service/management in the coming years.

KK: Insurers tend to differentiate themselves and support their brand strategies with claims management as a keystone. This strategic management approach increases the value of insurer's brand asset, and includes leveraging an enterprise view of the customer, strengthening vendor management, implementing innovative approaches to customer care, and increasing productivity to efficiently and accurately adjudicate claims.

Good claim services also significantly increases customer retention which in turn reduces customer procurement cost. Insurers can also tap a pool of potential customers, third parties involved in accident claims. To implement this requires a strategic approach that provides an enterprise view of existing and potential customers' relationships, with the necessary information and processes that cross insurance enterprise silos.

Strategically insurer should also collaborate in sharing loss data to prevent frauds, track stolen vehicle and understand evolving claims trend. In India, General Insurance Council has taken various initiatives in this direction which will surely benefit Indian insurance industry.

We differentiate from competitors in this area, first, by internally having a very independent claims function. Here, decision on payability or otherwise of a claim is taken solely by claims team and others cannot prejudice decision making. This independence of claims is hallmark of our company.

Tata AIG has rolled out several initiatives for its retail and corporate clientele. We were the first in Indian Insurance industry to come out with the concept of Toll free claim notification and claim status service, mobile car claims service, Key Point Garages with service warranty, Predictive claims – where claims are approved over phone during claim intimation, multiple channels of claim intimations, Status update via SMS to retail customers, Digital cameras and hand held devices to assist examiners to examine the losses etc.

None of the claims can be repudiated by operational offices. The decision to not to pay a claim is always taken by a very senior level of Claim managers at Corporate office. For corporate clients we offer customized SLA's (Service Level Agreements) , our USP is worldwide claim service through our strategic partners Chartis who have dedicated claims staff in 130 countries. This kind of worldwide reach cannot be replicated by other insurers.

We have a dedicated Special Investigation Unit to prevent fraud. In 2006 data on stolen vehicle collated by this unit was shared with all our competitors, this resulted in recovery of large number of vehicle for us and our competitors. This clearly demonstrates that strategically it makes sense in sharing loss data within the industry.

With insurance companies investing so much in technology today, how do you feel the quality of claims service has improved?

ND: As far as the claim function is concerned, the call centre/ helpline facility has been a major development which has ensured that the insured does not have to walk up to the insurance office for lodging the claim and furthering the process. Technology has helped insurance company in various ways, such

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Interview – *Claims : Three Dimensional View...* *Contd. # 10*

as monitoring the claims, profiling the customers for product specific selling , statistically analyzing the claims to study and forecast the claim trends, based on which insured can be properly advised on risk improvements etc. But I would say that we are still lagging in the use of technology in assessment/ surveying of the loss, which will go a long way in improving the claims cycle time even further. The next step, which is going to be very difficult, is to convince all the partners in the claims process, such as workshops, hospitals, salvage buyers and surveyors, to use the same technological platform for seamless service. If agreed upon by all, this will change the claims service scenario drastically.

KK: The first noticeable change that came for a customer was the ease and speed with which he can lodge claim now. Gone are the days when he had to go physically to the policy issuing office to bring claim form. He has a wide choice today – telephone call, SMS, email, lodging claim on net – in addition to the earlier option. SMS alerts of important stages in claims settlement also help him keep abreast of the progress. Cashless settlements have become norm in auto claims and health claims, all possible due to investments in technology. PDAs, Laptops, digital cameras, intelligent assessment tools are cutting down settlement times in auto claims. Thus, if you compare with earlier period, there is a much better claims experience today for a customer.

For a retail customer, the inherent emotional elements of a claim warrant that the Insurer must take into account his experience while his claim is being adjudicated and eliminate any inconveniences to him as a result of delays which are beyond the control of insurers.

Another factor which differentiate present day claim services has emanated from sales and service point of business: Claim officials are taught to have "empathy" in order to provide a proactive and fair claims service and "claims service" in itself has become a Product now.

The quality of the claims experience is bad in many cases because of poor customer awareness - he does not know what to do or expect at the time of a claim. What is stopping the industry from getting together and educating the customer so that claims settlement remains a smooth process?

ND: I agree that a lot is required to be done in this area. As stated earlier, brokers and agents play a crucial role in stabilising the insured's expectations in terms of the policy that they opt for. For example, in health insurance, the identity cards are most often than not considered as credit/swipe cards. This leads to a huge disappointment at the material time. Knowing that the customer is unlikely to read the policy/foot notes, an aggressive campaign for educating the customer through various channels such as bulletins, etc needs to be adopted.

KK: Majority of the players in insurance – save for the venerable LIC – are struggling to improve their market share & maintain profitability. Customer education is a 'higher' need if one plot's Maslow's Pyramid of organisational needs. There are some, slow steps being taken but overall, it is more busy with survival and sustenance to fully take up customer education.

However IRDA and GI Council have made some serious effort in this regard. General insurance products are quite sophisticated compared to other financial instruments purchased by a retail customer. Customers tend to compare FD, Life Insurance or a ULIP product with a general insurance product. The step that needs to be taken to make the retail customer aware about the intricacies of general insurance product has to be implemented at industry level. IRDA had taken major initiative in educating the customers through advertisement and publicity campaigns. Recently IRDA has urged the insurance companies to draft policy documents in simple language and demystify the complex legal jargons that tend to mislead people. Publishing policy documents in vernacular languages would also give better understanding of the policy conditions.

Over and above, Agents, Brokers and other Distribution partners also have to understand their role in the event of a claim and need to walk extra mile to educate their customers. An enlightened customer will be a repeat customer!

In the insurance industry (non-health), the idea of outsourcing claims function has always seemed too risky and insurers preferred keeping that business process closer to home. However things seem to be changing since insurers are finding that outsourcing can lead to bigger returns on investment, reductions in operating costs and improved customer service. What's your take on this?

ND: There are three factors behind the outsourcing of the business

a) Perceived cost advantage

b) Access to wider skill base

c) Difficulty in servicing remote areas

It is true that the scale of volumes will drive the cost factor down, as the outsourced agency will have the advantage of volumes. But as has been our experience, the talent pool required for such an activity is yet to be formed in India. So, in the present situation, the advantage of a wider skill base is not available. This may, in fact, lead to paying more through indemnity, while saving in the process cost. Personally, I feel the market has not matured enough to go in for full-fledged outsourcing just yet.

KK: The claims management is an intricate enterprise wide value chain that also includes a collage of outsourced services like: repair workshops, IRDA licensed surveyors, investigators, litigation specialists, subrogation services. Till date most of the insurers have not integrated these service providers with their "core" claims process and systems. This lack of integration results in claims files that are disjointed and information is scattered over several files. Orchestrating and integrating these independent processes of service providers, who are part of the preferred network, will allow claim staff and adjusters to direct, oversee, and intervene while management gains unprecedented visibility. Customers also receive faster service.

In my opinion significant opportunity exists in integration, rather than directly outsourcing the entire claim process. Innovations in technology, like service-oriented architectures (SOA) and Web

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services, have made this orchestration a reality for leading claims organizations, enabling insurers to streamline integration within their enterprises and with other applications. Recently Tata AIG has rolled out motor car survey evaluation application on mobile-web platform which allows the field staff to directly upload survey data into our system in real time.

Some of the non core claims function / routine work like registration of claim, allotment of survey job, preparation of claim cheque etc can easily be outsourced. Similarly, companies need to 'segment' claims, say into 'hi frequency, low complexity', which can be outsourced and 'low frequency, hi complexity' which can be handled in-house.

What about the climate of the market? When do you think the market will be turning the corner toward what the industry requires to sustain success going forward?

ND: The market is still cloudy. Business pressures are still dictating the terms. Frankly, I will not hazard any guess on this. Every day, every month and after every incident, one hopes that the market will see change. It has not happened till date on the expected scale. But of late, one can see a perceivable change in the mood to act and mend the market forces. It is happening in health now and I do not see any reason why will it not happen on an overall basis. Huge efforts are required for standardisation of labour in Motor & tariffing of charges in Health segment. Leaders in the industry must come forward to form coordination committee to address these issues jointly.

KK: Capital required to setup a General Insurance company in India is substantial. Still over last several years we have seen at least 2 new insurance companies entering market every year. Inflow of new capital in the market is keeping the insurance rate low, because each new insurer thinks that it can sustain underwriting loss for at least two/three years, and starts writing business at unviable rate. With each new insurer entering the fray; this self destructive cycle will persist. I think such low unsustainable rate may continue for some time till new investors find this sector unattractive. Meanwhile existing major private sector payers have become cautious which can be seen in their lower business growth trend and new found underwriting discipline.

Market savvy insurance companies will tap new opportunities in niche market under financial lines and liability class of business, also vast potential exists in rural insurance. However pricing of products, servicing capability and distribution reach will remain major challenge.

Many companies have burnt fingers, accepting risks at recklessly low premiums. They are now putting breaks, which is sensible thing to do. It is turbulent time for the non-life industry, with low unsustainable rates hitting the top-lines adversely. Whether market has spoiled or companies have spoiled market is a moot question. So, it is more to do "within" than blame it on market. Every year, there are a few new players, which tend to play the 'catch up' game and drop prices. So, stability is still a few years away.

The answer lies in growth of a more mature insurance sector, where prudent underwriting norms rule the roost and development oriented underwriters take decisions based on data and not on only market pressure Also, companies need to expand the pie, rather than fight for the same pie. This can happen in two ways – bringing in newer products (like environmental risk policy brought out by TAIG) and reaching new customers, in Tier-2/3 towns and rural areas. There is a tremendous opportunity in rural insurance, especially in weather insurance, crop insurance & health insurance. In urban areas, liability & health insurance will become important in days to come. Insurers will have to take the pains of creating newer institutions/ processes and leverage technology to tap these markets and service them.

With advent of more professional Brokers, Intermediaries and other new Distribution channels the sustainability of the Industry will improve and that will be the real win-win situation.

{Views expressed are personal & does not reflect the views of the Company}

News TitBits

IRDA sets caps on risk insurers cede to GIC Re

Source: DNA

IRDA has introduced caps under the obligatory cession made by direct insurers to GIC Re for various lines of general insurance including fire, industrial and marine risks, aviation, liability, machinery breakdown risks among others from the new fiscal. Irda has asked general insurers to segregate risks specifically, which, under the new rules, will have caps. In a letter, Irda has stated, "It has been decided that the obligatory cession of the sum insured on each policy to be reinsured with GIC Re for the year April 1, 2010, to March 31, 2011, shall continue to remain 10%. However, where the original insurance liability exceeds the sum insured … for each class of business, the percentage of the insurance to be reinsured with GIC Re shall be reduced to the extent necessary to limit the sum insured for the share of GIC Re."

GIC Re plans to create nuclear liability pool

Source: Blonnet

GIC Re plans to create a pool comprising insurance and reinsurance companies from India and abroad. GIC Re will be the manager of the pool. It is waiting for the Civil Liability for Nuclear Damage Bill, 2010 to be passed for greater clarity on the details. "We have made a presentation to the insurance regulator, IRDA. GIC Re will provide capacity and be a manager of the pool also. We are just doing the spade work and are waiting for the legislation to be passed. All the domestic insurance companies have informed us that they are willing to join the pool. We will also involve foreign reinsurers and insurers who are providing capacity at other nuclear sites around the world," said Mr Yogesh Lohiya, Chairman and Managing Director, GIC Re.

Max Bupa receives final approval from IRDA

L&T may start insurance biz in Q1 FY11, gets IRDA nod

Religare opts for solo entry into health insurance business

Interview – *Claims : Three Dimensional View*

Insurance Surveyor

From the customer's perspective; claims management is a slow, unclear process with practically no transparency. What do you believe can be done to bring in more transparency and information sharing in the claims process?

Mr. Rajan Srivatsan: I do not agree with you that claims management is an unclear and an opaque process. We deal with the Insureds in an open and transparent manner. There is no intention or attempt to take advantage of the Insured's ignorance of the Insurance practices. The advent of Brokers and Consultants has ensured that the entire process of claim adjustment is fair and reasonable to both the parties to the Insurance Contract. Further, the Insureds are fully aware of their rights and responsibilities under a contract which equally apply to insurance contracts. They use this experience and their common sense business approach to the claim process.

The Adjusters should create an impression in the mind of the Insured that he would be fair and reasonable even at the time of his initial visit. He should not behave in a high handed manner or in a manner suspecting the Insured or his claim. The attitude of the Adjuster is very important in making the process of claim adjustment a transparent process. If the Insured believes that the Adjuster would be fair and reasonable, he would be transparent with the Adjuster and the entire process becomes transparent. The Adjuster should give the information and documents required by him to assess the loss in one go. Asking for details piece-meal irritates the Insured. The adjusters should explain to the Insured the reason as to why they need the information sought, if the Insured wants to know. The Adjusters should give to the Insured, their final adjustment of the Insured's claim and the reasons for deduction or adjustments in the Insured's claim. If any adjustments are on account of application of policy conditions, it may be specifically brought to their notice. Issue of underinsurance, under-declaration etc., may be specifically put forth, so that the Insured may avoid the same in future by taking corrective measures.

What are some of the current challenges in the loss adjusting and claims areas?

RS: There a number of challenges in the loss adjusting and claims areas. The first and foremost is the lack of clear cut time lines. First source of delay is the Insured. In most of the cases, the Insured himself is not in a position to furnish the details called for by the Adjuster within a reasonable time. By the time the details are made available, the Adjuster could have got busy in some other new assignment and the continuity is lost. There is delay from the Adjuster's side due to his work pressure. If a claim is handled continuously from the time of its inception, it could be concluded in about 10 days, when everything is fresh in the minds of the Insured and the Adjuster. But picking up the threads later on after a long gap, really contributes to the delay.

The second challenge is the lack of fresh and young talent coming into the Survey and Loss Assessment field. This is a matter of serious concern to the insurers and the Insureds. This is essentially because the profession has been brought up as an individual oriented profession in stead of an organization oriented profession. We hardly have a handful of large survey and loss adjusting organizations in India which can attract young people. Even these Companies are not able to match the salaries of IT companies, Banks or Insurance Companies, Broking Companies. All other Surveyors or Survey Companies are only individuals who can not afford to pay high salaries. There is reluctance on the part of youngsters to join one-man companies. Survey Fees Structure has been designed with an individual in mind and does not help in developing the profession of survey and loss assessment. If this situation is not corrected in the near future, we may find that in a matter of 10 to 15 years, no surveyors would be available to adjust the losses. This is especially true in the case of property losses.

The third challenge is the lack of pool of knowledge amongst the Loss Adjusting Community. You need a lot of technical expertise to assess property losses. Similarly, expertise is required on the commercial, accounting, fiscal laws, foreign trade polices etc. The Adjuster thinks that introducing an Expert undermines his importance in the claim process. Lack of knowledge and expertise is likely to result either in over-payment of the claims or in a dispute. This deficiency could be traced to the rigid fees schedule and the need to take prior permission from the Insurer to appoint experts. Insurers should take this as an area for loss minimization and should advise the adjusters to appoint experts in case the adjusters feel they do not have the required expertise in certain aspects pertaining to the claim.

Many a times, insurers take months to settle a claim even after proper documentation is provided. What are the reasons for the delay? What are the ways to decrease the delay in claims settlement?

RS: There are several reasons for delay after the claim reaches the underwriters for settlement. One reason for the delay is that a file has to go through various offices, like Branch, Divisional Office, Regional Office and then finally the Head Office. The claim file is scrutinized by scores of officers each one of them will have their own perception of the claim and would have queries on different aspects. This is the case with Public Sector. PSU Insurers have also cut down the layers by introducing Corporate Cell or LCBs etc., so that the handling is limited to two offices only. Most of the private sector companies follow this practice. But then delays take place even with the private players. The delay in claim settlement is mainly arising out of queries being raised by the claim processing offices. Some queries can be answered by the Surveyor directly and immediately while some others require the Surveyor to get back to the Insured. This where the maximum delay takes place. The Insured will take time to give reply to the Surveyor who in turn has to vet the same and forward the same to the Insurer. Some claims get delayed

(Contd... 14)

because of some complaints about the genuineness of the claim or the quantum of claim or the circumstances surrounding the claim, when there is a lingering doubt in the minds of the Surveyor/ Insurer. Delays occur due to underwriting errors as well. Like, location or property is wrongly given in the policy. Insurers take time to sort out these issues before the claim is settled. Sometimes, delay takes place due to the appointment of a surveyor not suitable for the job on hand, like a stock claim being handled by an Engineer Surveyor or a Machinery Break Down being handled by a Chartered Accountant Surveyor

According to me, the ways to decrease the delay in claim settlement are:

1. Proper and error-free underwriting;
2. Pruning of layers of claim processing;
3. Check list for the Claim Processing Officers;
4. Clear cut procedure for dealing with anonymous letters and complaints
5. Appointing the right Surveyor depending on the type of loss

What steps do you think can be taken towards educating the customer on the process of claims documentation?

RS: Generally, the Customers are well aware of the process of claim documentation. For a smaller client, since he is all alone, it takes time to collect all the requirements of a Surveyor. In a large Company, you very rarely find an executive who is fully dedicated to Insurance related work. Insurance is always found tagged on to some other main function, in most of the cases with finance. For them, finance function is primary and insurance is secondary. I have seen in several cases, when I give the letter of information requirements, the concerned insurance person, will take copies of my LOR, mark the same to different persons in the organization. His job is only to collect the data and hand over to the Surveyor. Customers should be educated that Insurance is an important aspect of their business to lack of knowledge and understanding of the subject, a lot of money could be lost, by way of improper insurance, under-insurance etc.,

What in your opinion is the major difference in the approach taken by Private insurers as against PSU insurers towards claims settlement?

RS: Major difference in approach in claims settlement between the Private Insurers and PSU Insurers is in decision making – like resolving/ rectifying underwriting errors; admissibility of the claim; negotiated settlement etc. These are decided then and there by Private Insurers. But the PSU Insurers, being Government Companies, can not take such on the spot decisions.

Customers have a general opinion that the surveyors, having been appointed by insurers are biased at times towards the Insurer in the assessment of a claim? Your comments please.

RS: I do not agree. By and large Surveyors are independent and neutral. Simply because, they are appointed and paid by the Insurer, you can not question their impartiality. But in matters of interpretation of policy conditions etc., we go by the Insurers interpretation, since they are the authors and have issued the Policy. As far as the assessment is concerned, we are totally independent. Very rarely, the Insurers interfere in the loss assessment.

How do you think it would help if there is a panel of surveyors decided upon at the time of policy placement itself? Can the surveyors play a more vital role in advising customers on loss prevention and minimization in case involved before a claim?

RS: It would be a good idea to have an agreed panel of surveyors at the inception of the Policy. The Insured and the Insurer could choose the Surveyors with whom both the parties are comfortable and who would do a thorough job of assessment in a transparent and impartial manner. This would avoid disputes in claims. The Insured also can not complain about the Surveyor, since the list is approved by him. Another advantage of such a panel is that the surveyors from the Panel would be fully conversant with the Insured's industry and it would make the Insured's job simpler.

In my opinion, the Surveyor should stop with Survey and Loss Assessment. Getting into areas like loss prevention, minimization etc., for which he receives fees from the Insured, would not be viewed favourably by the Insurers. The Surveyor should not have any commercial connection with the Insured in any manner. If he has such a connection, he should disclose it to the Insurer and desist from undertaking any loss assessment work for such a client. There would definitely be a conflict of interest.

Statistics suggest that the need for claims adjusters is going to increase significantly. But is the talent for that readily available? Where do you see the future pool of new adjusters coming from?

RS: I agree with you. General Insurance business is growing, despite a fall in fire premium rates. The need for quality claim adjusters is increasing by the day. But, unfortunately, no new talent is coming into the field. Hardly, we see young Loss Adjusters in the field. Even those who come into this field, go off to other intermediaries like brokers. Trained young Surveyors are in good demand even from Insurance Companies. It has been difficult to get people into the Survey Profession and it is more difficult to retain them against competition. Talent is not readily available. It takes at least two to three years to train a young Engineer or Chartered Accountant, to do a reasonable job of a Survey. The only practical way of creating a pool of new adjusters, appears to be a tripartite arrangement amongst the Insurer, Survey Firm and the Trainee, that he would undergo training under the Surveyor for three years, get himself qualified in Insurance examinations and the Insurer would absorb him into their Company after a minimum of three years. This would assure a long term career for the young Surveyor, in case, he would not like to make Insurance survey his long term occupation and at the same a continuous pool of young talent would be available to the Surveyors as well as the Insurance Companies. This needs to be given a serious thought and implemented.

{Views expressed are personal & does not reflect the views of the Company}

Interview – *Claims : Three Dimensional View*

Corporate

As a company with such a wide geographical spread, how do you manage the risks? What controls and monitoring procedures do you have in place?

Mr. P C Somani, Supreme Industries: Based on the past experiences, we have taken the following measures in preventing/ controlling the wide spread geographical risks:

- Fire hydrant systems are installed at all the plants with sufficient water storage tanks.
- Storing/stacking methods of the stocks, such as maintaining adequate distance from the ceiling, walls and the floor.
- Use of fire resistance materials wherever possible.
- Lesser no. of lights in the warehouse, wherever, possible.
- Installation of advanced automatic switch ON/OFF system, for ex. When the shutter is closed all the electric connections gets disconnected.
- Appointment of Risk Advisors for Health, Safety and Environment who also make plant inspections at regular intervals and keep management well apprised apart from initiating required risk improvement measures at the site.

What are the key parameters on which you decide an insurance partner?

PCS: Two top parameters are for deciding an Insurance Company are:

- Past Experience which includes servicing
- Relationship

Then pricing too plays a role being a visible component in terms of costs but we found our existing service providers very competitive. After the detariffing of the policy wordings in future, role of the Insurance Brokers and their expert advice would be key in decision making. Although new players belong to reputed business houses, still at the moment PSU companies give better degree of comfort at the back of mind.

What has been your experience as far as claims are concerned? Can you please share with our readers the largest claim that you have faced in terms of quantum till now and your experience on the way it was handled by the Insurer / broker and the surveyor?

PCS: Experience regarding claims has been quite satisfactory. Except for one fire claim which was encountered in the year of 1997 where the need was felt to refer the claim to the process of arbitration. However, the same was resolved mid-way during the process of arbitration.

The largest claim which we have encountered till date was a fire claim in the year of Aug 2001 for an amount of Rs.7 crores which involved stocks of finished goods in the warehouse located inside the factory premises near Gwalior. Surveyors were appointed from Delhi. The claim was settled amicably and smoothly in the month and year of May 2002.

How quickly were you able to arrange for the required documentation as required by the surveyor? Were you convinced about why the Insurer and Surveyor had asked for the set of documents….. were they justified?

PCS: We were able to provide the documents very quickly as they are maintained separately and plant wise. Yes, we were convinced about the documents asked by the surveyors, however, requirements could be enormous depending upon the complexities of the claim and sometimes documents are requested by the Insurers/surveyors in bits and pieces which results in delay in the claim settlement.

In general how has your experience been with the Insurance Companies in terms of service and settlement? Was there some uncovered risk that took you by surprise? In case there were some underwriting gaps, were these rectified during the renewal of the policy?

PCS: We have been mainly dealing with the PSU's and they were and are very co-operative in their approach towards the settlement of the claim. As such we have not encountered any uncovered risks which took us by surprise. We have also not encountered any underwriting gaps. However, as a company policy till 2007, we were taking the policies on Market Value basis for all the assets, which presently are being taken on Reinstatement value basis.

Was there any gap between your expectation and the insurer's settlement? Do you feel the difference is justified?

PCS: Yes, there were certain gaps with regards to our expectation with the policy.

- While obtaining the cover for finished goods at market value, we have specifically defined the term "Market Value" which was Selling Price of the Goods less un-incurred expenses, if any; which means apart from the costs, profit is also to be covered. Although the Policies are issued at "Market Value" the same is not defined in the policy. We continue to declare our stocks as per our definition which was communicated to Insurance Company while taking the policy. We find the gap in the definition of "Market value" as understood/ communicated by us and as interpreted by different surveyors/ Insurance companies.
- There could also be gap regarding the depreciation to be considered in case of Market Value settlement. Since this is dependant on so many factors apart from individual opinion, we feel that the depreciation rates agreed between insurer & insured should be part of the policy document.

Your suggestion to Insurers to improve the quality of the claims servicing?

PCS:

- Insurance Company should appoint the Surveyors from the region of loss location which would facilitate the claim process both for surveyors and the insured.
- Clearly defining the terms, parameters agreed between Insurer and insured in the policy document to avoid different interpretation by different people/authorities.

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View Point - *Handling Claims... is there 'the best way'?*

A customer while placing the risk and an insurance company, while accepting the risk, both do it with the earnest intention of, in the eventuality of a claim arising, they should be able to settle it amicably in the best and fair interest of the customer. There have been innumerable claim discussions we have participated in over the past several decades. Customer dissatisfaction is at its peak when it comes to claims settlement..... In majority of the cases, both, the insurer and customer are satisfied with each other until there is a claim. Be it as an insurer or a broker, there is a great deal of post claims analysis done. Now only if we could be spending as much time on this while underwriting or immediately post underwriting, there is a possibility that the experience of claims handling may be more pleasant for both the parties concerned. Why is it that we do not spend as much time before a claim? True, accidents do happen, but is there a way to reduce the ill will that comes along and also in the process bring down the magnitude of loss or avoid the loss in itself?

To a large extent I would put the onus of this situation we are in today, on the customer, insurer and the adviser too. There has hardly been a couple of occasion in which during the entire process of placing a risk does the customer think about the claim in the initial stages. The entire discussion during policy placement revolves around 'Price, price and .....price' followed by a couple of standard 'add ons'. The insurer and broker too in their bid to close the deal are only too anxious to bend backward to all of the customer's demands! What is it that prohibits the customer from demanding how a claim is to be processed, or understanding the nuances of the policy? Is there any unwritten rule that these things are not to be talked about during placement? The more we emphasise on price, the more difficulty in getting the claim settled. Very aptly, this term is now being referred to as 'Claims underwriting' rather than a 'Risk underwriting'. While the very large customers have been getting into these discussions, the neglected lot are the small and medium sized customers who are caught up more on the number games or get brownie points from their management for getting a reduction in premium!

Take for example the large number of customers, who, having taken a Fire policy covering their fixed assets/ stocks had been caught unawares. Guided by their agents / brokers they deleted the Plinth and foundation value from the fire risk and included it only for the Earthquake risk so as to have a reduction in premium. The reason given by the 'advisers' to the gullible customer being 'there is no chance of a fire damage happening to the Plinth and foundation' and you can have a reduction in premium too. Unfortunately, these customers had to dig into their own pockets when the 2005 Maharashtra floods had left several cracks in the plinth of the buildings, or when continued fire destroyed the steel rods in the foundation! While, the Plinth and foundation value is deleted from the fire risk, little does the customer realise that it is being deleted from the risks arising out of the allied perils too!

This apart, while talking to customers across the country, one finds very few satisfied customers, particularly after having faced a couple of claims. Where is it that things generally go wrong? Broadly we can classify the reasons for dissatisfaction as given below:

Underwriting lapses: In a bid to close the deal at the most competitive rate, a judicious analysis of the risk hardly ever takes place. The right covers to be taken to be adequately protected, the right values to be declared for insurance, all these need to be looked into so that the customer is satisfied with the final claim cheque that he receives

Absence of reviewing of the subject of insurance once placement is completed: This results in subsequent additions remaining uninsured and thereby increasing the percentage of underinsurance in the event of a claim

Post placement discussion – Insurer – customer – panel surveyor. Post placement, rarely do we hear of discussions taking place with the customer on how to handle a claim, or what are the improvements that can be made in the subject matter so as to reduce the chances of a loss taking place. It would be a proactive measure to have periodic risk mitigation exercises by the Insurer/ broker/panel surveyor.

Lack of transparency with customer: The complicated Insurance English in fine print being used in the policies do not in any way help the customer realise what is covered and what is not. We blame the customer for not reading the policy, but even if he reads, would he be in a position to comprehend it?

'Claims underwriting' attitude of Insurer: Genuine underwriting unfortunately takes place only after a claim has occurred.

Escalation in claim value by insured: This is found to be a standard practise..... the insurer anyway never pays what we ask for, so let us claim an additional 10-20%. This attitude of several customers, results in the insurer being guarded and microscopic in settlement of all claims.

The time is now ripe for all the players to mature and work towards a common goal of achieving satisfaction in claim settlement.

- GSV Ramanan, VP, India Insure.

Disclaimer

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