KPMG Consulting

INSURANCE SECTOR ASSESSMENT

Final Report

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EXECUTIVE SUMMARY

Section I – Introduction and Objectives

The Government of India has recently opened the insurance sector to competition after an extensive period of state-owned monopolies. The Insurance Regulation and Development Authority (IRDA) was created to serve as the regulator of the business of insurance.

USAID has been asked by IRDA to provide technical assistance and training under the Indo-US Financial Institutions Reform and Expansion (FIRE) Program in order to promote and support development of the sector.

The objective of the Task Order executed with Barents Group of KPMG Consulting was to identify opportunities for USAID intervention with technical assistance and associated training in the following areas:

- Institutional capacity for regulation and supervision by the IRDA
- Development of the health insurance and managed health care sector
- The status of management information processes at both the IRDA and within the insurance industry
- The status of consumer protection in the business of insurance
- The adequacy of the professional training, research and education infrastructure and curriculum
- Opportunities for broadening and deepening the insurance markets in India

The assessment was conducted using the following standards in evaluating possible USAID interventions:

- The degree to which any intervention will support Strategic Objective 11 of the Mission (Increased Capacity of Financial Markets and Government to Transparently and Efficiently Mobilize Resources).
- Whether the interventions will be reasonably calculated to result in building institutional capacity in the insurance sector.
- Whether the interventions necessary are those for which USAID/India has comparative advantage.
- Consciousness of the activities of other donors or other resources available to IRDA, the supporting professions or the commercial marketplace.
- An awareness of the issues and constraints that may affect the success of any interventions.

Section II -- Discussion and Analysis of Issues and Constraints

Task 1. Institutional capacity for regulation and supervision by the IRDA

- The main technical and competency issues facing IRDA are:
  - Lack of technical competence and training on solvency supervision
  - Lack of competence, data and training to put in place a risk-sensitive early warning system to identify troubled insurers
  - Training on claim administration oversight
  - Lack of technical competence and training on pricing of insurance products
  - The need for a compendium of insurance accounting principles adhering to international standards and the production of an industry audit guide for insurance companies for use by statutory auditors
  - Lack of procedural manuals for all processes of an insurance supervisor
  - Capacity for introducing a risk-classification system
  - Lack of a mandatory valuation mortality table constructed using generally accepted actuarial standards
  - Lack of effective oversight control over foreign reinsurance

- IRDA needs a table of organization that manages the core functional activities of insurance supervision. These are:
  - Legal
  - Actuarial
  - Off-site financial supervision
  - On-site inspections
  - Market conduct examinations
  - Consumer affairs
  - Licensing of all market participants
  - Reinsurance
  - Review of contracts and rates
  - Information Technology Support
  - Human resources and other supportive services
  - Top-level policy analysis capacity
  - Co-ordination with regulators of other financial institutions

Task 2. Development of the health insurance and managed health care sector

"Health insurance" needs to be defined to address all risk-transfer or intermediation situations, including health insurance and managed healthcare.

Currently, public and private schemes provide financing and provision of healthcare to around only 10% of the population (100 million people). There is an absolute need to properly develop fair and competitive health insurance and managed healthcare markets to expand access and coverage, to mobilize resources, and to obtain cost-effectiveness and quality of care.

Some key issues and constraints are the following:

- Lack of national healthcare policies.
- Absence of proper standards and procedures and their implementation for the licensing and accreditation of healthcare facilities and professionals.
- Unregulated and undirected flourishing of high-tech hospitals and laboratories causing further distortions in the healthcare system.
- Lack of reliable and sequential healthcare statistics.
- Extremely high out-of-pocket healthcare financing (75%) at the point of service, mainly paid by low-income people.
- Extremely low public expenditures in healthcare at less that 1% of GDP (US$18 billion).

Obstacles of this nature are not uncommon in environments in which the public sector played a monopolistic role. The private sector will enter into the Indian health insurance market if conditions are laid out for a fair and competitive setting, with proper but not cumbersome regulations.

Task 3. The status of management information processes at both the IRDA and within the insurance industry

IRDA needs to be able to use the data it is requesting from insurers. These data are (or should be) statistics intimately related to the financial condition (both current and prospective) of the insurers. Information is the foundation of solvency supervision and it must be reliable and analyzed rapidly and efficiently.

Moreover, the insurance companies need reliable and actuarially credible statistics in order to predict loss costs and design premium rates. The insurance industry has not maintained these types of data in the form and in the detail that is required. The state-owned insurers have no incentive to share their information with their competitors.

Hence, there will need to be a commitment to requiring by law or regulation all of the insurers to report raw loss costs and ultimate mortality and morbidity data (these are not trade secrets in these media) plus losses based upon classification of risk.

Task 4. The status of consumer protection in the business of insurance

The IRDA Act mandated the Authority to ensure the "protection of the interest of policy holders…" The ability and effectiveness of the IRDA in performing this enormous task depend primarily on the strength of its organizational set-up and human resources. At this point these platforms are inadequate.

- IRDA needs to use its authority to formulate, issue and implement regulations to provide standards of best practices in the industry.
- IRDA must build its technical and administrative competence of the IRDA to:
  - ◊ Establish a Consumer Affairs Office under its auspices to monitor, receive and promptly handle consumer complaints.
  - ◊ Establish and maintain competent human resources to review and assess sufficiency of substance and reasonableness of policy forms, premium rates, and other filings of insurance products being offered in the market.
  - ◊ Establish an effective mechanism to monitor and assess existing business conducts and undertake financial and market surveillance.
  - ◊ Build the competence of self-regulatory institutions/organizations adopting strict membership rules in conformity with internationally accepted standards.

Task 5. The adequacy of the professional training, research and education infrastructure and curriculum

There are two main issues respecting the state of specialized insurance education available in India:

- Are there sufficiently qualified professionals in the various areas concerning insurance for the industry to develop in a solid and modern fashion?
- What are the training needs for IRDA to achieve levels of high competency and excellence as the insurance, and eventually the pensions, regulator?

Like any new or restructured industry insurance needs to rely on capable, well trained, updated, and dedicated human resources. There appears to be an excellent infrastructure upon which improvements can be based.

The opening of the insurance market to competition poses the following questions:

- Is the current educational and training infrastructure able to satisfy the needs of the new Indian insurance industry?
- Will the private insurance sector establish its own training establishments to the detriment and possible demise of part of the existing State insurance-oriented training infrastructure?

IRDA's only concern as the regulator is that well-qualified insurance professionals are being produced. However, IRDA has the further role of assisting in the development of the insurance sector so it must act as a leader in encouraging modernization and expansion of the curriculum.

IRDA is in the process of completing hiring its personnel. So far, both at the management and technical levels, human resources come from the public sector, mainly from the State insurance system. IRDA's senior management acknowledges the weaknesses of the current staff and of the staff it may be able to bring into IRDA.

The current curricula of the formalized educational institutions are not designed to train insurance regulators. Accordingly, IRDA has an interest in encouraging design of such courses.

Task 6. Opportunities for broadening and deepening the insurance markets in India

The issues and constraints in relation to the initiatives to broaden and deepen the Indian insurance market are:

- The technical and administrative competence of IRDA to administer and regulate a free market insurance environment
- The willingness of the state-owned companies to open the market under conditions of fair play and competition
- The lack of local talents with technical expertise and experience operating an insurance business in a free market.
- LIC's "exclusive" access to "subsidized" insurance. This condition will certainly affect the ability and willingness of the private sector to aggressively develop a market in the economically deprived sector.
- The immediate and growing needs to upgrade the technical and professional expertise of local industry professionals.
- The overall lack of insurance awareness and responsiveness in the economically deprived sector. This sector makes up the greater majority of the market.

Section III -- Suggested Program of Technical Assistance and Associated Training

IRDA's Institutional Capacity

A rational and sequenced plan for technical assistance and associated training intended to build capacity within IRDA could include the following elements:

The technical competence of the IRDA to formulate, issue and implement regulations to provide standards of best practices in the industry, particularly in the following key issues:

- Preparation of comprehensive manuals for off-site financial condition analysis and for on-site inspections
- Licensing and prescribing minimum financial and professional requirements for non traditional channels of product distribution.
- Prescribing minimum disclosure requirement in the solicitation and sale of insurance and life-financial services products.
- Prescribing suitability requirements for owners, directors and officers of insurers and other risk-takers.
- Prescribing rules governing insurance holding companies, affiliates and subsidiaries.

- Establish of a Consumer Affairs Office under its auspices to monitor, receive and promptly handle consumer complaints.
- Establish and maintain competent human resources.
- Establish an effective mechanism to monitor and assess existing business conducts and to undertake financial and market surveillance and/or "on-site" examinations.
- The legal limitation of the IRDA to exercise its powers to promulgate regulations other than for technical and administrative matters
- The ability of the IRDA to manage and direct the utilization of its funds
- Availability and competence of self-regulatory institutions/organizations to adopt strict membership rules in accordance with the standards international standards.

Technical assistance and training to build an organizational and institutional framework and to develop qualified professionals.

- USAID should focus only on process-based training and leave broader knowledge-based training to others This involves "hands-on" guidance in real-life insurance supervisory situations and being able to do the job daily. This is where USAID has a significant comparative advantage because it can call on a number of resources in the USA – such as the National Association of Insurance Commissioners, the International Insurance Foundations and the International Insurance Council – to provide practical training.
- The insurance industry, with the oversight of IRDA, must actively promote the formation of SROs and other professional organizations.

Health Insurance and Managed Healthcare

The following broad areas are identifiable needs for IRDA technical assistance and training in which USAID has strong comparative advantages with its ability to call upon resources able to assist in building a rational private health insurance and managed healthcare system.

Institutional capacity. To cope with these challenges, IRDA needs to build its regulatory capacity. So far, IRDA has completed the composition of its high management with a progressive and widely respected Chairman. IRDA should consider the establishment of a Health Insurance Unit or Department.

IRDA will have to develop the technical capacity for the issuance of regulations related to health insurance and managed care. Examples include, for instance:

- Capital and staffing requirements;
- Intermediaries such as Third Party Administrators, and agents;
- Minimum requirements for health insurance contracts;
- Risk pooling;
- Resource allocation;
- Multi-payer systems;

- Performance-based contracts;
- Purchasing regulations;
- Governance and monitoring;
- Actuarial requirements;
- Standards for claim payments;
- Advertising;
- Prudential regulations;
- Reporting; and
- Claims settlement procedures.

Ministry of Health. There is a clear perception that one of the major problems in the healthcare sector is the unregulated and low quality of providers. It seems obvious that the MOH needs to improve the licensing and accreditations procedures to ensure minimum quality of care. Licensing of healthcare professionals including physicians, nurses, technicians both in western and traditional medicine, and accreditation and re-accreditation of all healthcare facilities, including hospitals, clinics, ambulatories, pharmacies, laboratories, and other medical providers, should be a priority.

Management information processes at both the IRDA and within the insurance industry

The IRDA database needs are particularly within the area of comparative advantage for USAID since it has significant experience in technical assistance projects that have designed databases for virtually all types of financial institutions regulators. Accordingly, IRDA will need technical assistance and training in the following areas:

- Data management;
- Creating a central shared database;
- User functional requirements;
- Data entry and submission;
- System requirements;
- Report specifications;
- Data ownership;
- Data storage.

The industry-specific database should be operated by a "rating and statistical organization" (RSO). This organization should be owned, operated and funded by the insurers and IRDA interest will be as its regulator. Thus, USAID ought not to appropriate technical assistance resources to the actual operation and methodology of the RSO. However, to the extent that IRDA has a function, technical assistance can be useful in:

- Identifying the level of sophistication existent in the industry and the ability of insurers to organize and operate a statistical organization dedicated to rate-making procedures
- Describing a plan for IRDA to begin the leadership of this task because it is in the interest of IRDA to have reliable statistical information in the industry

- Presenting the legal and other prerequisites that need to be resolved in order to institute such an organization and process and assure IRDA quality control.

Consumer protection

We have identified the following areas for effective USAID intervention:

- Assist the IRDA in setting up a functional table of organization.
- Assist the IRDA in developing prudential and regulatory provisions to reinforce the soundness of the insurance market and the protection of consumers of insurance products.
- Assist the IRDA in developing stricter business conduct standards.
- Assist the IRDA in developing adequate insurance contract laws, rules governing contractual rights and obligations and related sanctions.
- Assist the IRDA in formulating and adopting adequate, effective and prompt measures to prevent companies from defaulting in their contractual obligations and a mechanism to secure orderly business run-off and/or portfolio transfer to other sound companies.
- Assist in the building and reinforcement of self-regulatory principles and organizations that will supplement and complement the regulatory structure.
- Assist in the building and development of strong principles of corporate governance and to prescribe guidelines designed to encourage the industry to promote and adopt training structures for industry practitioners.
- Assist in establishing an agency or facility specially empowered to mediate or arbitrate industry disputes and consumer's complaints.
- Assist in establishing standards prescribing suitability requirements of owners, directors and officers of insurers and other risk-taker practitioners.

The adequacy of the professional training, research and education infrastructure and curriculum

Formal Training Establishments

- It would be important to have independent and objectives ratings of the many educational institutions**.** IRDA could benefit from USAID's expertise in attracting advisors who would be able to set up the necessary mechanisms for certifying the educational quality, but only to the extent it serves a regulatory purpose of IRDA.
- Insurance Agents' Training.
- Professional Associations (Self-Regulatory Organizations*)* While the SROs are theoretically not a matter for supervisors, IRDA has a regulatory interest in the development of SROs. USAID has a definite role in assisting IRDA in promoting competent and disciplined SROs.
- The number of qualified actuaries is in extremely short supply. Notably, there are no casualty actuaries. USAID may be able to support the planning for a formal program of training and certifying casualty actuaries.

- Surveyors/adjustors. The profession must be made competent, professional and a representative of the interests of insurers and insureds. Support should be given to IRDA in establishing a policy concerning training surveyors and their licensing.
- Lawyers. There is a need for trained lawyers conversant in commercial law and insurance. For a start, IRDA needs to have a competent legal department with well-trained and reputed lawyers to manage regulation and their interpretation and implementation, dispute resolutions and litigation matters.
- Accountants. One potential problem for the insurance industry is the duality of Indian and international accounting and auditing standards.
- Underwriters. Finally, and very critically, there is a total lack of attention to building the skills of a professional underwriting (risk assessment) discipline.

Market Penetration

USAID can assist in developing strategic measures and training to the IRDA and other targeted entities in the following areas of concern:

- Promoting the development of new products – such as crop insurance, title insurance, mortgage guaranty insurance, death expenses insurance – that can gain traction in the marketplace and lead to more efficient mobilization of resources in the economy.
- Assisting IRDA in formulating standards for licensing of agents, brokers and other distribution intermediaries and of monitoring their market conducts.
- Promoting insurance awareness especially in the economically deprived sector by providing special technical assistance to distributors of insurance products in the economically deprived sectors, such as the micro-finance entities, rural bankers, and cooperatives.
- Providing techniques and training in regard to gathering, assembly, creation and maintenance of national risk statistics, risk information exchange among all the insurance companies as a facility to effectively calculate risks and associated premiums.

Conclusions And Recommendations

Capacity building

Based upon our analysis, we have concluded that the insurance sector in India requires extensive technical assistance and training. While there are some barriers and constraints, we believe that most, if not all, are transitory and will be eliminated as the market matures.

As noted in our introduction, the insurance sector is an essential element of USAID's Strategic Objective 11. Even during the period of transition from a newly competitive industry to one that is more mature, USAID will be achieving tangible results in building institutions and capacity. USAID will be assisting in preparing the market for full liberalization; will be creating confidence in the insurance sector that currently does not exist; and will be creating institutions that will be steering a more effective mobilization of resources.

Additionally, no economy can modernize without a reliable insurance mechanism – it is essential to managing the risks that must be managed in order to achieve greater economic development.

Finally, the insurance sector is an integral part of the "financial institutions" of a modern economy. Its role as a financial intermediary is no less important that its function as a risk-management intermediator. The function that insurance plays as a financial intermediator has tangible benefit to the development of capital markets and other investment needs of India. Its role as a risk intermediary is essential to any pension reform that will provide for annuity payments to retirees.

USAID's technical assistance should encompass three (3) phases over approximately a five-year period. Note, the following topics are general – the specific activities that could be included are set forth in Section 3.

The first phase – accomplished in the first 18 months to 24 months would be focused on building the basic organization and staff skills of IRDA.

- Assessment of IRDA's organization and staffing and staff rationalization
- A gaps analysis of the laws and regulations
- Training needs assessment
- A thorough review of the procedures used by IRDA and a recommended plan for streamlining and improving efficiency
- Training on risk-based supervision
- Creation of an India-specific Early Warning System
- Preparation of manuals of practice and procedure for all phases of IRDA activities
- Building the IRDA's specialized authority and capacity in the area of health insurance and managed healthcare in terms of legal foundations and training
- Studying and implementing the statutory predicates for a meaningful dispute resolution system to protect consumers
- Diagnostic, action plan and phasing (over a three or four year period) for a comprehensive Indian Insurance Supervision System (IISS)
- Preparation of a regulatory accounting practices and procedures compendium
- Institution of process-based training
- Presentation of insurance-awareness workshops
- Formation of a working group to eliminate the TAC and replace it with a RSO
- Action plan for instituting an insurance industry-funded casualty actuarial program
- Establish prudential rules for foreign reinsurance
- Attempt liaison with Ministry of Health

The second phase – scheduled around the 18th to 42nd months (and which may involve some continuation of phase one activities) would be focused on building advanced skills for IRDA.

- Creation of models for managed healthcare systems and quality assurance
- Formation of a working group to design an Indian mortality table
- Formation of a working group to design both life and non-life underwriter (risk assessment) certification and require all insurers to have qualified underwriters
- Standards for both upward and downward deviations from Tariffs set by the TAC
- Conduct on-site market conduct examinations
- Oversee on-site financial condition examinations
- Intensive training through interaction with USAID advisors
- Training abroad for advanced students
- Introduction of broader use of IISS
- Mandatory electronic format filing of financial statements of insurers
- Planning of an NBFI strategy and liaison
- Workshops for the industry on designing new products to meet market demands

The final phase – scheduled for around the 36th to 60th months (and which will likewise involve continuing activities from phases one and two) will be focused on instituting modern insurance supervision practices in the IRDA:

- Introduction of a train-the-trainers educational program within IRDA
- Introduction of career development incentives to IRDA staff
- Creation of IRDA's own financial condition inspection unit
- Mandatory on-line filing of financial statements with IRDA
- Continued intensive training of IRDA personnel through interaction with USAID advisors
- Final phases of IISS running.

SECTION I –INTRODUCTION AND OBJECTIVES

Introduction

The Government of India recently liberalized the insurance sector after an extensive period of state-owned monopolies in both the life and non-life segments of the business. This liberalization involved, *inter alia*, the creation of the Insurance Regulatory and Development Authority (IRDA) to serve as the regulator of the business of insurance; the means for insurers owned by the private sector to market insurance after meeting registration requirements; the amendment of the Insurance Act of 1938 to remove some restrictions on the insurance business; and a facility for non-Indian investors or joint ventures to participate in the Indian insurance market.

The insurance mechanism involves payment in advance for a future benefit. Thus, the industry deals in promises and there is a strong public interest in assuring that the companies making the promises will be able to keep their promises in the future. Additionally, in the context of building a modern economy and encouraging development, the insurance mechanism is an important financial intermediary and risk-transfer modality. Insurance also plays a very important role in asset protection and national savings through life, endowment and annuity contracts. A healthy and reliable life insurance sector is a essential to any strategy of pension reform that is designed to provide income replacement to retirees and their beneficiaries

IRDA is currently endeavoring to put in place essential elements of insurance regulation and supervision and it has asked USAID/India to provide technical assistance and training under the Indo-US Financial Institutions Reform and Expansion (FIRE) Program in order to promote and support development of the sector.

Accordingly, USAID/India executed a Task Order with Barents Group of KPMG Consulting to conduct an assessment of the insurance sector in six critical areas:

- Institutional capacity for regulation and supervision by the IRDA,
- Development of the health insurance and managed health care sector,
- The status of management information processes at both the IRDA and within the insurance industry,
- The status of consumer protection in the business of insurance,
- The adequacy of the professional training, research and education infrastructure and curriculum, and
- Opportunities for broadening and deepening the insurance markets in India

A team of three experts (the Team) was assembled with particular skills in regulatory best practices, tools and techniques, international health insurance and managed health care models for developing economies and the opportunities for penetration of insurance services into emerging markets. The Team spent one week in Washington, DC discussing the activity and gathering background. The Team then spent three full weeks of intense research and evaluation

throughout India. The Team Leader remained in India throughout the remainder of the Task Order and the other Team members returned to the USA, but continued work on drafting of the report and responding to comments. A complete listing of interviews conducted is attached as an Annex to this report.

We delivered an informal mid-term oral progress report and we also delivered an oral debrief to USAID/India senior management.

Objectives

This Task Order is to assist USAID/India in understanding the Indian insurance sector, particularly the aspects related to legal, regulatory, institutional and market practices and inadequacies. Further, we intend to identify opportunities for USAID assistance that can assist this newly-competitive industry. Finally, we will identify institutional gaps that may be remedied by USAID interventions.

Any such interventions have been a considered based upon the following standards:

- The degree to which any intervention will support Strategic Objective 11 of the Mission (Increased Capacity of Financial Markets and Government to Transparently and Efficiently Mobilize Resources).
- Whether the interventions will be reasonably calculated to result in building institutional capacity in the insurance sector.
- Whether the interventions necessary are those for which USAID/India has comparative advantage.
- Consciousness of the activities of other donors or other resources available to IRDA, the supporting professions or the commercial marketplace.
- An awareness of the issues and constraints that may affect the success of any interventions.

What we have attempted to avoid is substantive policy discussions or to suggest that USAID should attempt to play a major role in policy-making. However, some references to policy were unavoidable because of the influence some key issues have on expected outcomes.

Finally, we have been advised that if USAID/India determines that intervention into the insurance sector is warranted, the plan is for a long-term commitment of resources – perhaps as long as five years. Accordingly, we have also been asked to include our recommendations regarding sequencing of various technical assistance and training activities along the pattern of near-term, medium-term and long-term activities.

In order to assist the readers of this report, we have organized it following the outline of the six major tasks. Thus, each major section of this report will be divided into those six subsections.

SECTION II -- DISCUSSION AND ANALYSIS OF ISSUES AND CONSTRAINTS

Task 1. Institutional capacity for regulation and supervision by the IRDA

There are a number of issues and constraints faced by the IRDA and, consequently, matters that must be addressed either by IRDA alone or in concert with USAID. We are highlighting the major institutional constraints that apply to IRDA – in our discussion of issues and constraints respecting the other major tasks, we will be discussing precise issues and constraints applicable to the respective topics.

- IRDA must have an earmarked, adequate and reliable source of funding. Currently, the funding of the IRDA (.20% of first-year premiums) is apparently adequate and wholly-dedicated to funding IRDA. As the demands upon the authority become more extensive, however, there must be a means to assure the sufficiency and security of the funding mechanism. Without adequate budgets and the ability to recruit and retain qualified staff, no regulatory authority can be effective.
- IRDA is currently under-staffed and yet there is a desire to limit the number of employees. That may be laudable in the interests of efficiency and streamlining the regulatory process. However, that must not be achieved at the expense of establishing an insurance supervisory authority that has the capability to perform all of the functions required in modern insurance supervision. A concerted recruiting and training program must commence.
- We will be recommending a technical assistance initiative focused on designing and training on a regulatory database for IRDA. IRDA must be willing to invest in the personnel, hardware and software necessary to support the system
- The main technical and competency issues facing IRDA are:
  - Lack of technical competence and training on solvency supervision
  - Lack of competence, data and training to put in place a risk-sensitive early warning system to identify troubled insurers
  - Training on claim administration oversight
  - Lack of technical competence and training on pricing of insurance products
  - The need for a compendium of insurance accounting principles adhering to international standards and the production of an industry audit guide for insurance companies for use by statutory auditors
  - Lack of procedural manuals for all processes of an insurance supervisor
  - Capacity for introducing a risk-classification system
  - Lack of a mandatory valuation mortality table constructed using generally accepted actuarial standards (the industry now uses the mortality experience of LIC during 1994 – 1996 in lieu of a true mortality table)

- ◊ Lack of effective oversight control over foreign reinsurance

- IRDA needs a table of organization that manages the core functional activities of insurance supervision. These are:
  - ◊ Legal
  - ◊ Actuarial
  - ◊ Off-site financial supervision
  - ◊ On-site inspections
  - ◊ Market conduct examinations
  - ◊ Consumer affairs
  - ◊ Licensing of all market participants
  - ◊ Reinsurance
  - ◊ Review of contracts and rates
  - ◊ Information Technology Support
  - ◊ Human resources and other supportive services
  - ◊ Top-level policy analysis capacity
  - ◊ Co-ordination with regulators of other financial institutions

Task 2. Development of the health insurance and managed health care sector

According to the latest World Bank estimates, public and private schemes provide financing and provision of healthcare to around only 10% of the population (100 million people). There is an absolute need to properly develop fair and competitive health insurance and managed healthcare markets to expand access and coverage, to mobilize resources, and to obtain cost-effectiveness and quality of care.

The actual and proper development of the health insurance and managed healthcare industries in India faces some constraints. Some issues to consider are:

(1) The dominance of public sector companies.

(2) The 26% equity limitation on foreign partners in joint ventures may reduce available capacity to build an health insurance or managed care business.

(3) Lack of comprehensive national healthcare policies.

(4) Absence of proper standards and procedures and their implementation for the proper licensing and accreditation of healthcare facilities and healthcare professionals and technicians.

(5) Unregulated and undirected flourishing of high-tech hospitals and laboratories causing further distortions in the healthcare system.

(6) Lack of reliable and sequential healthcare statistics.

(7) Extremely high out-of-pocket healthcare financing (75%) at the point of service, mainly paid by low-income people.

(8) Extremely low public expenditures in healthcare at less that 1% of GDP (US$18 billion).

Obstacles of this nature are not uncommon in environments in which the public sector played a monopolistic role. Opening the market requires sustained political will, legislation, public polices, regulatory authority *and* the willingness on the part of the state bureaucracy to change, to reform, the current system. The private sector will enter into the Indian health insurance market if conditions are laid out for a fair and competitive setting, with proper but not cumbersome regulations. The IRDA may play a critical role in:

- Defining health insurance and managed healthcare policies.
- Subjecting all public and private insurers to the same regulations and procedures.
- Properly regulating the health insurance and managed care industries.
- Facilitating and coordinating the reform of the current financial and delivery healthcare system.

Currently, private insurance companies seem to be exploring the Indian market and evaluating opportunities and constraints. IRDA is yet to receive applications for health insurance licenses. Experienced and quality international technical cooperation and training can make a substantial contribution to the effective opening and development of health insurance in India

In servicing the poor, all insurance companies need to comply with IRDA Regulation on Obligations of Insurers to Rural and Social Sectors. This regulation states that in the social sector[1] general insurers (and health insurance is classified under general insurance) need to cover 2% of gross premium income in the first year, 3% in the second financial year and 5% thereafter; and in the rural sector from 5,000 lives in the first financial year to 25,000 lives in the fifth financial year.[2]

Community-based programs for assisting the poor and the low income self-employed are of extraordinary importance in India. They provide micro-credit primarily to the poor and the self-employed in the informal sector, primarily women. Some of these support schemes have included various forms of health insurance. Many call these programs with different names to avoid formal regulation and supervision.

For instance, the Self-Employed Women's Association (SEWA) is a trade union of more than 2 million workers in the informal sector. SEWA has a health insurance scheme with two of the public insurance companies, Life Insurance Corporation of India and the New India Assurance Company, Limited, whereby annual premiums cover maternity, hospitalization, some occupational diseases, and other ailments on women's health. SHARE, a micro-finance institution in Andhra Pradesh, is developing a program to assess women's' health issues in the rural areas to develop health programs to benefit SHARE members. This program, to be called

[1] Numeral 2 of IRDA regulation on Obligations of Insurers in Rural or Social Sectors of 2000, defines social sector as the one including "unorganized sector, informal sector, economically vulnerable or backward classes and other categories of persons, both in rural and urban areas", and "rural sector" as meaning any place as per the latest census which has (i) a population of not more than five thousand; (ii) a density of population of not more than four hundred per square kilometer, and (iii) at least seventy-five percent of the male working population engaged in agriculture.
[2] IRDA Regulation on Obligations of Insurers to Rural and Social Sectors of 2000, numeral 3.

"emergency health fund", would engage physicians, laboratory technicians and will focus in primary health care.

Task 3. The status of management information processes at both the IRDA and within the insurance industry

IRDA needs to be able to use the data it is requesting from insurers. These data are (or should be) statistics intimately related to the financial condition (both current and prospective) of the insurers. Information is the foundation of solvency supervision and it must be reliable and analyzed rapidly and efficiently.

Moreover, the insurance companies need reliable and actuarially credible statistics in order to predict loss costs and design premium rates. This will be of great importance to the private sector insurers who have no current basis for rate-making decisions other than the standards of Tariff Advisory Committee. These uncertainties add to the cost of insurance, introduce threats to solvency and, most importantly, result in misallocations of insurance costs and incorrect mobilization of resources and funds.

The IRDA has no current capacity – either in terms of human resources or in equipment – to manage effectively and rapidly financial condition information and other filings of insurers. However, IRDA has finalized its Management Information System requirements and has entered into a provider contract. Additionally, a software package is being developed. These initiatives could benefit from assistance in design of software and training of IRDA personnel on its use.

Likewise, the insurance industry has not maintained these types of data in the form and in the detail that is required. The state-owned insurers have no incentive to share their information with their competitors.

Hence, there will need to be a commitment to requiring by law or regulation all of the insurers to report raw loss costs and ultimate mortality and morbidity data (these are not trade secrets in these media) plus losses based upon classification of risk.

Task 4. The status of consumer protection in the business of insurance

IRDA is mandated to protect the interests of every consumer of insurance product. It shall regulate and develop the insurance industry establishing and maintaining public confidence by ensuring that all insurers continue to operate their businesses with adequate capital and the prescribed the level of solvency at all times. In finer terms, the IRDA is the ultimate guardian and protector of policyholders' and the insuring public's interests.

IRDA will need to acquire both technical and administrative expertise that will enable it to maintain a regulatory regime that both promotes industry productivity and builds strong consumer confidence ensuring sustainable industry growth. At a minimum, it must also endeavor to shape and form the country's legal and regulatory framework according to the twenty (20) points guideline recommended by the Organization for Economic Cooperation and Development

(OECD) to ensure efficient, fair, safe and stable insurance markets for the benefit of the policy holders.

Confronted with these challenges, IRDA needs to develop career regulators to constantly ensure a respectable health of the industry and to properly administer regulations under a free-market regime with reasonable dispatch.

There are a number of institutional weaknesses in consumer protection:

- Existing insurance laws and regulations do not yet fully conform to the guidelines recommended by the OECD concerning a minimum standard in establishing and maintaining an efficient, fair, safe and stable insurance industry.
- Insurance remains a contract of adhesion. Unilaterally, the insurer writes and issues policy contracts on its own terms and conditions. Consumers of insurance products, the "weaker" party in insurance contracts, should be protected. The current insurance laws of India by expressed provisions ensure broad protection to consumers of insurance products. However, since the IRDA was constituted, several regulatory initiatives have been introduced.
- Lack of Insurance Awareness and Product Responsiveness. This topic is also discussed in Task 6-Broadening and Deepening of the Market. We include this subject as a part of consumer protection for the reason that every consumer of an insurance product must be able to discern his rights and obligations under the policy. A great part of the market needs basic insurance education and a even greater portion in the economically deprived sector does not even know what insurance is. The industry needs to adopt programs promoting and enhancing consumer education, starting with the insurance program they are offered to buy. In many jurisdictions, the same disclosure requirements when delivering the policy contract.
- Lack of Active Independent Institutions for Consumer Protection Advocacy are required. There is no known consumer protection advocacy institution that independently gathers unbiased industry information to be made available to buyers of insurance products, to the print and broadcast media, insurance schools, industry practitioners, the IRDA.
- Complicated policy wordings. Consumers of insurance products are not familiar with legalistic and technical terms. Insurance policies and riders are pre-printed long forms. Most consumers do not bother to read policies, nor understand their rights and obligations thereunder.
- Unfair Trade Practices. Under a liberalized market, where competition is dynamic, vigilance for unfair trade practices is a necessary element of consumer protection.
- Regulatory Capacity. IRDA requires strengthening of its staff better to monitor the protection of consumers and the fairness of the marketplace.

It is noteworthy that the IRDA, even with its current staffing limitations, is issuing regulations designed to protect insurance consumers. Notable among these regulations are the following:

- Prescribing the Actuarial Report and Abstract reportorial requirements for life and health insurers.

- Insurance Advertisement and Disclosure standards.
- Prescribing licensing and training requirements and code of conduct for insurance agents.
- Requiring every Life Insurance company to employ and continue to employ the services of an Appointed Actuary.
- Definition of Assets, Liabilities and Solvency Margin requirements of insurers.
- Prescribing general procedures and requirements for registration of insurers.
- Prescribing standards and forms for the preparation and submission of financial statements and auditor's report for every insurer.
- Investment regulations.
- Prescribing licensing, minimum professional requirements and code of conduct for Surveyors and Loss Assessors.
- Prescribing time frames for the settlement and payment of valid claims

The Role of the Insurance Companies in Consumer Protection:

- Insurers have the duty to educate their policyholders on their rights and obligations in the policy contracts. They have to make disclosures about the product being offered. They must provide for procedures and requirements in the submission of proof of loss statements to ensure the facilitated settlement of claims.
- The use of policy forms with "easy to read" wordings, for a better understanding of the policy contract, will be prompted by the privately owned insurers.
- Competition will push improvements in claims adjudication and settlement practices. Regulations prescribing qualifications and norms of business conduct of surveyors and loss assessors further enhance consumer confidence.
- Selling of insurance will include basic disclosure elements on costs and benefits to promote consumer awareness and product responsiveness in the market.
- Competition will drive companies to improve corporate governance and will motivate them to raise the levels of technical competence of underwriters, actuaries, marketers, policy-owner service and other company staff.
- Industry regulations prompt the building of professional full-time career agents, brokers, and other distributors of insurance products.

Task 5. The adequacy of the professional training, research and education infrastructure and curriculum

There are two main issues respecting the state of specialized insurance education available in India:

(1) Are there sufficiently qualified professionals in the various areas concerning insurance for the industry to develop in a solid and modern fashion?

(2) What are the training needs for IRDA to achieve levels of high competency and excellence as the insurance, and eventually the pensions, regulator?

Like any new or restructured industry , insurance needs to rely on capable, well trained, updated, and dedicated human resources. During the Indian insurance monopoly era a number of establishments flourished offering courses and training in insurance to satisfy the needs of the State insurance industry. The State insurance company-sponsored formal educational and training establishments targeted managers and executives. There appears to be an excellent infrastructure upon which improvements can be based.

The opening of the insurance market to competition poses the following questions:

- Is the current educational and training infrastructure able to satisfy the needs of the new Indian insurance industry?
- Will the private insurance sector establish its own training establishments to the detriment and possible demise of part of the existing State insurance-oriented training infrastructure?

IRDA's only concern as the regulator is that well-qualified insurance professionals are being produced. However, IRDA has the further role of assisting in the development of the insurance sector so it must act as a leader in encouraging modernization and expansion of the curriculum.

IRDA is in the process of completing hiring its personnel. So far, both at the management and technical levels, human resources come from the public sector, mainly from the State insurance system. IRDA intends to have a total cadre of around 54 staff and no branches. Given the majestic task of regulating and supervising the emergence and development of a modern insurance industry, the question arises regarding the actual and potential capability of IRDA to cope with this major task. IRDA's senior management acknowledges the weaknesses of the current staff and of the staff it may be able to bring into IRDA.

The current curricula of the formalized educational institutions are not designed to train insurance regulators. Accordingly, IRDA has an interest in encouraging design of such courses.

Task 6. Opportunities for broadening and deepening the insurance markets in India

Our meetings and discussions with the USAID-New Delhi Mission, IRDA, several NGOs, Insurers, professional associations, micro-finance entities and other organizations representing adequate cross-sectional interests in the industry, coupled by our readings of previous reports, research, studies and other materials concerning insurance in the country, provided us with a clearer picture of the current market and the degree and extent of market penetration particularly in the economically deprived sector.

We have identified a number of weaknesses:

- General Affordability of Insurance Premium. Effective and sustainable market penetration depends on the ability of the market to absorb the cost of insurance which is, after all, an

additional expense. Increased savings and higher standards of living cause people to be more aware and responsive to the needs to protect their assets, incomes or financial security. Further complicating affordability is the Tariff Advisory Committee rates which are not based upon sound actuarial principles and that the fact that insurers are not permitted to charge a lower price than the tariff for good cause shown. Only rates higher than the tariff are permitted. This of course does not allow efficient insurers to compete on the basis of price and it effectively insulates poorly managed companies from the discipline of the market.

- Very Low National Awareness in Insurance Products/Benefits/Costs. Most of the products reaching the economically deprived sector are generated through banks and other financial entities as a result of lending activities. The small borrowers adhere to the coverage to obtain the loans. Policies are written in small amounts, determined by the lender for their interests, and are not offered on the basis of "real" needs of the insured.

- Lack of Alternative Distribution Channels. Before liberalization insurance products, both life and non-life, are distributed mainly through a modified agency-type channels. A company-paid "Development Officer" operates this distribution center. Agents are attached to a particular development officer who earns overrides as additional remuneration. It can be argued that the system of distribution through the "Development Officers" registered remarkable market penetration in so far as number of policies written and number of lives reached by insurance is concerned. Admittedly however, in terms of sum insured and quality of coverage, the protection afforded to the economically deprived sector is deemed inadequate, inconsequential and insignificant. Products are sold to generate sales and premium with little regard to the insured's need(s). The competitiveness of an insurance product depends on the insurer's ability to offer products that cover only the specific "needs" of the buyer. "Needs" selling also promotes and facilitates insurance awareness.

- Exclusivity of Subsidized Insurance to LIC. The Government of India, in its efforts to alleviate the conditions of the economically deprived sector, has several social security-based schemes that make available group insurance to approved groups. Premium for this Rs 5,000 group basic life insurance is subsidized under the Social Security Group Insurance Scheme. We have not analyzed the cost effectiveness of the premium as we have verified the fact that the premium is entirely subsidized: one half drawn from the social security fund maintained by the LIC and one half is paid by the state government. We feel that this subsidy should likewise be accessible for the products of private insurers to assist them penetrate this market.

- Encourage and motivate active participation of the private companies in deepening the market. Design and market innovative insurance products that are not intended to cater only to the middle and upper classes, but make available insurance with larger sum insured at competitive costs to the social class. The IRDA must keep vigilant on the "social obligation" that private companies are likewise mandated to develop.

- We also note the interests of the private companies to access the economically deprived market. We have seen some market dynamism as they attempt to forge and shape alliances with banks and micro-finance entities.

- Lack of Competition Retards Product Design and Quality. Understandably, because of the long period of monopoly, employment-based group insurance policies are written and

administered by the LIC. By its very nature, these blocks of business are "locked in," a condition that discourages competition. As discussed earlier in this report, the subsidized insurance should also be accessible for the products of privately owned companies so that they can compete in the economically deprived sector and allow them to rationalize product design and pricing in this sector.

- The quality of business is poor. Except in regard to coverage afforded by group insurance schemes (employment-based and subsidized programs), we were informed that the persistency rates for individual life are below acceptable business and growth standards. For example, we were informed by LIC that its persistency rate during the 13^{th} to 25^{th} month for life policies was only 13%. More than 25% of life policies lapse during the first three years. The degree and extent of market penetration is shallow because of high "lapse" rates in individual life policies and the low renewal rates in non-life coverage particularly in the economically deprived sector. To broaden and deepen market penetration life policies should persist long enough for benefits to accrue; and for non-life policies to renew concurrent with the economic needs secured by the coverage.
- Lack of Reliable Actuarial Tables and Industry Statistics and Qualified Property and Casualty Actuaries to Promote Effective Pricing of Products. The business of insurance depends on analysis, management and utilization of large numbers. From this group of large numbers are developed actuarial tables as a means of approximating degree of risks. Experience data are then assimilated to these tables in order to fix a reasonable amount of risk premium.

SECTION III -- SUGGESTED PROGRAM OF TECHNICAL ASSISTANCE AND ASSOCIATED TRAINING

In this section, it is our aim to identify a number of areas in which the capacity-building, technical assistance and training capabilities of USAID would be useful. We are not presuming to design such a program – that role is rightly and solely that of USAID. We are merely attempting to assist USAID in understanding the various initiatives and interventions that are possible.

IRDA's Institutional Capacity

A rational and sequenced plan for technical assistance and associated training intended to build capacity within IRDA could include the following elements:

The technical competence of the IRDA to formulate, issue and implement regulations to provide standards of best practices in the industry, particularly in the following key issues:

- Preparation of comprehensive manuals for off-site financial condition analysis and for on-site inspections. It is the plan of IRDA to contract with qualified insurance auditors to conduct these inspections until such time as IRDA has its own capacity. However, IRDA must be involved in planning the inspections, determining emphasis and enforcement and follow-up.
- Licensing and prescribing minimum financial and professional requirements for non-traditional channels of product distribution.
- Prescribing minimum disclosure requirements in the solicitation and sale of insurance and life-financial services products.
- Prescribing suitability requirements for owners, directors and officers of insurers and other risk-takers.
- Prescribing rules governing insurance holding companies, affiliates and subsidiaries.
- Prescribing regulations concerning supervision and conducting examinations on market conduct to include: products and pricing, allowable investments, capital and surplus adequacy, accounting practices, and unfair trade practices.
- Establising a Consumer Affairs Office under its auspices to monitor, receive and promptly handle consumer complaints.
- Establish and maintain competent human resources to review and assess sufficiency of substance and reasonableness of policy forms, premium rates, and other filings of insurance products being offered in the market. This is particularly important in a relatively newly liberalized market especially because current rules adopt the "file and use" system.
- Establish an effective mechanism to monitor and assess existing business conducts and to undertake financial and market surveillance and/or "on-site" examinations.
- Elimination of the legal limitation of the IRDA to exercise its powers to promulgate regulations other than for technical and administrative matters. The independence of the IRDA from the Central Government is a continuing issue.

- The ability of the IRDA to manage and direct the utilization of its funds. The Act provides for assessments as the source of funding the operations of the IRDA. As of this moment, IRDA begs for funding from the Central Government (general fund).
- Availability and competence of self-regulatory institutions/organizations to adopt strict membership rules in accordance with international standards.

Technical assistance and training to build an organizational and institutional framework and to develop qualified professionals.

There are two types of training programs that can be useful to insurance regulators. The first of these is "knowledge-based" training. That is to say, learning the theory and philosophy of a discipline. Examples would be accounting, study of the law, actuarial science, regulatory economics, etc. While this is essential to a well-trained insurance supervisory authority, USAID has no particular comparative advantage in this area. There are numerous opportunities both within and without India and it is for IRDA and the industry and its supporting professions to promote this knowledge-based learning.

However, the second type of training essential for insurance regulators is "process-based" training. This involves "hands-on" guidance in real-life insurance supervisory situations and being able to do the job daily. This is where USAID has a significant comparative advantage because it can call on a number of resources in the USA – such as the National Association of Insurance Commissioners, the International Insurance Foundations and the International Insurance Council – to provide practical training. Additionally, both long-term and short-term advisors will be well positioned to provide this type of training on a daily basis.

The insurance industry, with the oversight of IRDA, must actively promote the formation of SROs and other professional organizations.

Health Insurance and Managed Healthcare

The following broad areas are identifiable needs for IRDA technical assistance and training in which USAID has strong comparative advantages with its ability to call upon resources able to assist in building a rational private health insurance and managed healthcare system.

Institutional capacity. To cope with these challenges, IRDA needs to build its regulatory capacity. So far, IRDA has completed the composition of its upper management with a progressive and widely respected Chairman. So far, none has significant private sector experience. There are no staff members with previous experience with private health insurance. IRDA should consider the establishment of a Health Insurance Unit or Department staffed with competencies to include health economists, actuaries, health insurance and managed healthcare experts and lawyers with appropriate experience to take charge of regulation, licensing and supervision of all health insurance and managed care schemes.

Policy framework. If a solid and well-established health insurance industry is to develop, IRDA would have to prepare, discuss with all stakeholders, and approve a viable Health Insurance and Managed Care Industry Strategy. This strategy should include:

- Proper definition of health insurance and of managed care and corresponding procedures for licensing and operating.
- Appropriate supervision of all public and private health insurance schemes and structures for transferring financial risks related to healthcare in any form and under any name.
- Regulatory strategy to support the establishment and consolidation of health insurance and managed care, avoiding micro-management and cumbersome regulations.
- Strict supervision of financial, managerial and quality of care performance by insurance companies, managed healthcare organizations (MCO) and their healthcare providers.

Examples of additional policy questions to be addressed following the idea of a uniform and transparent system of health insurance and managed care, regardless of the number and type of players and of the name of the various products, should include:

- Should health insurance companies and MCOs be separate legal entities from general insurance companies?
- Should healthcare-related products attached or additional to life insurance policies be subject to IRDA approval, regulation and supervision?
- Should all health-related products currently marketed by the public insurance companies be submitted to IRDA for approval, regulation and supervision?
- Should all health-related schemes promoted and managed by micro-finance institutions and non-governmental organizations be submitted to IRDA for approval, regulation and supervision?

Licensing. Licensing of health insurance companies should be a process including compliance with formal regulatory requirements, and quality and competence of providers.

IRDA should regulate, perhaps in coordination with the Ministry of Health, the purchase of services by insurance companies and MCOs and indirectly standardize the provision of care using the power of licensing the financing of health care through health insurance. In doing so, IRDA should require, and thus ensure, that only duly licensed and accredited healthy care professionals and healthcare facilities are contracted by insurance companies. Concerning capital requirements, IRDA should consider lowering the capital requirements for health insurance companies and MCOs because risk financing is limited and the main activity which is the financing of services and this requires less initial capital and less reserves.

Third Party Administrators (TPAs). Issues like this one highlight the need for a better definition and understanding of the role that various actors can and should play in a regulated insurance market. TPAs should be perceived not just as agents of insurers – they should also be required to act as and able to deliver essential intermediation services that are fair, impartial and cost-effective.

Regulations. IRDA needs to gradually develop its capacity (technical or otherwise) to regulate health insurance and MCOs. Developing this capacity includes defining and detailing the

regulatory functions of IRDA in monitoring supervision, and control (What to regulate? How to regulate? How to supervise? What and how to control?). It also includes the coordinating role of IRDA with the Ministry of Health (MOH) and other enabling institutions.

IRDA will have to develop the technical capacity for the issuance of regulations related to health insurance and managed care. Examples include, for instance:

- Capital and staffing requirements,
- Intermediaries such as Third Party Administrators and agents,
- Minimum requirements for health insurance contracts,
- Risk pooling,
- Resource allocation,
- Multi-payer systems,
- Performance-based contracts,
- Purchasing regulations,
- Governance and monitoring,
- Actuarial requirements,
- Standards for claim payments,
- Advertising,
- Prudential regulations,
- Reporting, and
- Claims settlement procedures.

IRDA has the opportunity to develop itself into a sound, competent, capable, fair, and reliable regulatory and supervisory institution. It has the right leadership right now, but regulatory institutions need to build capacity, competence and operational traditions that are trustworthy, not cumbersome, and a stimulus for a well functioning healthcare insurance market. IRDA needs to perform, and be perceived to perform, as a sound, capable and competent regulator by the public, the health insurance companies and MCOs.

MOH. There is a clear perception that one of the major problems in the healthcare sector is the unregulated and low quality of providers. It seems obvious that the MOH needs to improve the licensing and accreditations procedures to ensure minimum quality of care. Licensing based on modern procedures of healthcare professionals including physicians, nurses, technicians both in western and traditional medicine, and accreditation and re-accreditation of all healthcare facilities, including hospitals, clinics, ambulatories, pharmacies, laboratories, and other providers needs should be a priority.

Since adequate supply of healthcare providers is critical for health insurance and managed care, IRDA needs to establish formal coordination mechanisms with the MOH to support urgently needed efforts to upgrade licensing and accreditation, and to require and allow only licensed healthcare professionals and accredited healthcare facilities to be used by health insurance and managed care systems.

Self-Regulatory Organizations (SRO) like the Indian Medical Association, the Medical Council of India, and other professional associations such as those for pharmacies, laboratories, nurses, etc., need to play a key and active role in standardizing and upgrading the practicing standards and procedures with strict qualification requirements and with continuous education programs for re-licensing. These procedures should be duly designed, properly monitored, and supervised.[3] Consumer groups and issue specific associations such as cancer, diabetes, and leprosy societies, should also play role in consumer awareness and in contributing to demand the raising of delivery standards of care.

Management information processes at both the IRDA and within the insurance industry

Clearly, there are two parts to this issue – one is wholly within the purview of IRDA and that is its own information management and automated early warning system requirements. The other applies to the insurance industry and its need to create a repository of statistical information that is vital to making insurance rates that are neither excessive, inadequate nor unfairly discriminatory.

The IRDA database needs are particularly within the area of comparative advantage for USAID since it has significant experience in technical assistance projects that have designed databases for virtually all types of financial institutions regulators. Accordingly, IRDA will need technical assistance and training in the following areas:

- Data management;
- Creating a central shared database;
- User functional requirements;
- Data entry and submission;
- System requirements;
- Report specifications;
- Data ownership;
- Data storage.

The industry-specific database should be operated by a "rating and statistical organization" (RSO), in other words, an organization that gathers and analyzes insurance-related claim experience and rating information to assist the insurance companies in making rates based upon credible actuarial information and also assists IRDA in developing required mortality, morbidity and annuitants' tables for the purposes of establishing reserves.

This organization should be owned, operated and funded by the insurers and IRDA's interest will be as its regulator. Thus, USAID ought not to appropriate technical assistance resources to the actual operation and methodology of the RSO. However, to the extent that IRDA has a function, technical assistance can be useful in:

[3] A recent initiative for continuous medical education by the Indian Medical Association has been criticized for lack of proper design and absence of monitoring capacity.

- Identifying the level of sophistication existent in the industry and the ability of insurers to organize and operate a statistical organization dedicated to rate-making procedures.
- Describing a plan for IRDA to begin the leadership of this task because it is in the interest of IRDA to have reliable statistical information in the industry.
- Presenting the legal and other prerequisites that need to be resolved in order to institute such an organization and process and assure IRDA quality control.

Consumer protection

While consumer protection is primarily a duty of government, the interplay, cohesion and coordination of the roles of the regulator, industry practitioners both in the public and private sectors, self-regulatory capabilities of professional organizations and institutions involved in the industry, consumer affairs advocates and continuing public awareness need to be established and maintained particularly in a competitive environment. We have identified the following areas for effective USAID intervention:

- Assist the IRDA in setting up a functional table of organization, increasing its geographical regulatory presence, and training and strengthening the technical and administrative abilities of its human resources in order to ensure the public's accessibility to adequate customer protection mechanisms.
- Assist the IRDA in developing prudential and regulatory provisions to reinforce the soundness of the insurance market and the protection of consumers of insurance products.
- Assist the IRDA in developing stricter licensing requirements to ensure stability of the industry and adequacy of the financial resources of insurance companies including uniform regulations prescribing reasonable guidelines for companies to comply in regard to legal, accounting, and technical requirements including criteria to ensure suitability standards for owners, directors and officers of insurance companies (corporate governance).
- Assist the IRDA in developing adequate insurance contract laws, rules governing contractual rights and obligations and related sanctions. This legal framework is extremely important because current regulations adopt the "file and use" system of registering and marketing of insurance product.
- Assist the IRDA in formulating and adopting adequate, effective and prompt measures to prevent companies from defaulting in their contractual obligations and a mechanism to secure orderly business run-off and/or portfolio transfer to other sound companies. In this connection laws and regulations governing business conservation, rehabilitation and/or liquidation of defaulting companies must also be developed and /or reinforced.
- Assist the IRDA in prescribing strict rules of licensing of intermediaries, (including financial guarantees and or errors and omissions covers for brokers) and minimum standards of disclosures on the products they offer and of the degree of their independence and/or extent and limits of their authorities. These matters provide a working mechanism for consumer protection.

- Assist the IRDA in planning and developing strategies that will provide a platform to encourage NGOs and other independent private institutions in building and forming strong and fundamental public awareness in insurance and as facilities for consumer affairs advocacies.
- Assist in the building and reinforcement of self-regulatory principles and organizations that will supplement and complement the regulatory structure.
- Assist in the building and development of strong principles of corporate governance and to prescribe guidelines designed to encourage the industry to promote and adopt training structures for industry practitioners.
- Assist in establishing an agency or facility specially empowered to mediate or arbitrate industry disputes and consumer's complaints.
- Assist in establishing standards prescribing suitability requirements of owners, directors and officers of insurers and other risk-taker practitioners.

The adequacy of the professional training, research and education infrastructure and curriculum

Formal Training Establishments.

India has a large number of institutions dedicated to formal education and training at various levels. Some of them give academic degrees and most award certificates. It would be important to have independent and objective ratings of these institutions with information on licensing, content and quality of education and training, faculty, funding, and placement record**.** IRDA could benefit from USAID's expertise in attracting advisors who would be able to set up the necessary mechanisms for certifying the educational quality, but only to the extent it serves a regulatory purpose of IRDA.

Insurance Agents' Training. IRDA has approved 47 insurance agents' training centers nation-wide, divided into four zones (Northern, Eastern, Southern and Western). There may be alternative methods for training agents that do not involve traditional methods – for example, e-training or inter-company programs.

Professional Associations (Self-Regulatory Organizations) While the SROs are theoretically not a matter for supervisors, IRDA has a regulatory interest in the development of SROs that provide high-quality professionals to work in the industry and perform competently as well as its role as the promoter of insurance development in India. In those regards, USAID has a definite role in assisting IRDA in promoting competent and disciplined SROs.

Actuaries. The number of qualified actuaries is in extremely short supply. The Actuarial Society of India has only 213 members, of which around 100 are overseas. Most of the ones in India are reportedly of older average age. One of the drawbacks of the insurance nationalization period was the virtual disregard for the critical input of actuaries. This attitude prevented the adequate advance of actuarial education and professional development. Prices/premiums were set up bureaucratically and the State monopoly found no incentive for actuarial analysis and for risk management research and evaluation. The situation at present is that with the opening of the

market for public and private competition, there are insufficient numbers of actuaries to satisfy the potential demand by the new insurance sector. Notably, there are no casualty actuaries.

The Actuarial Society is aware of this situation and it is trying to interest a younger generation of actuaries. Regrettably, the low esteem of the profession and consequent low-income prospects has diminished these efforts. Support should be provided to the Actuarial Society to allow a new breed of young actuaries to take their exams and obtain their qualification certificates without major obstacles. Current linkages with related institutions in the United Kingdom could provide the avenues for this endeavor. Additionally, USAID may be able to support the planning for a formal program of training and certification of casualty actuaries. This would involve limited technical assistance to begin the process, but the major funding must come from the insurance industry. In any event, a good tradition in mathematical education in India should provide sufficient number of candidates to become actuaries if the profession offers positive outcomes.

A significant additional challenge to the actuarial profession is put forward by IRDA regulation on Appointed Actuary and on Actuarial Reports and Abstracts. The insurance industry may be able to formally fulfill these requirements with available actuaries, but insurance companies may have to train or bring in their own actuaries to properly perform these tasks.

Further, IRDA needs to build a capacity to analyze actuarial reports and abstracts. IRDA needs to incorporate into its staff qualified actuaries, and expect increasing salaries and status competition from the private sector.

Surveyors/adjustors. The profession must be made competent, professional and representative of the interests of insurers and insureds. As the insurance industry is developed, there will be demand for specialized surveyors with professional backgrounds in engineering and other professions to adjust claims in highly technical areas. Support should be given to IRDA in establishing a policy concerning training surveyors and their licensing.

Lawyers. The insurance industry is abundantly regulated with laws, regulations proper, instructions, letters of interpretation and the like. It is a largely normative industry. Thus, there is a need for trained lawyers conversant in commercial law and insurance. For a start, IRDA needs to have a competent legal department with well-trained and reputed lawyers to manage regulations and their interpretation and implementation, dispute resolutions and litigation matters.

Insurance training programs for lawyers are a great need. The Indian Law Institute could play a valuable role in this regard.

Accountants. The Institute of Chartered Accountants of India has more than 100,000 active members. The Institute has its own Act of Parliament and it is a fairly independent entity. The Institute sets accounting and auditing standards. One potential problem for the insurance industry is the duality of Indian and international accounting and auditing standards. Gradually, we hope sooner than later, India should move towards the adoption of international standards in the financial sector.

The Institute provides traditional accounting education and training, usually in three-week training sessions. However, there were no plans announced to provide education and training in modern insurance and in international standards.

Underwriters. Finally, and very critically, there is a total lack of attention to building the skills of a professional underwriting (risk assessment) discipline.

Market Penetration

We find that the degree and extent of market penetration of insurance are both limited and shallow. Several factors may have contributed to this condition foremost of which is the general economics of the country as 75 percent of the nation's population are grouped in the low-income-poverty/below poverty classifications. The national per capita GDP and GDS are relatively low to provide a healthy market segmentation and market targets. The long years of monopoly, especially in the life sector, and the methodology of product distribution (primarily confined to a modified agency type system) failed to generate quality insurance products that are essentials to sustain a broad and deep market penetration. Affordability of insurance did not seem to be an industry priority because of the lack of competition. Product packaging and development and the principles of "need" selling were not aggressively pursued by the monopolistic regime. The overall national insurance awareness and product responsiveness is very much wanting.

In the order to implement these tasks, we recommend that the USAID assist in developing strategic measures to help broaden and deepen the insurance market of India by extending technical assistance and training to the IRDA and other targeted entities in the following areas of concern:

- Strengthening the IRDA's ability to build and expand its regulatory capacity, particularly in market conduct supervision, so that it can adequately function as the chief protector of the insuring public and promotes insurance awareness.
- Promote the development of new products – such as crop insurance, title insurance, mortgage guaranty insurance, death expenses insurance – that can gain traction in the marketplace and lead to more efficient mobilization of resources in the economy.
- Assisting the IRDA in formulating and prescribing rules of licensing of agents, brokers and other distribution intermediaries and of monitoring their market conducts.
- Promoting insurance awareness especially in the economically deprived sector by providing special technical assistance to distributors of insurance products in the economically deprived sectors, such as the micro-finance entities, rural bankers, and cooperatives.
- Providing techniques and training in regard to gathering, assembly, creation and maintenance of national risk statistics, risk information exchange among all the insurance companies as a facility to effectively calculate risks and associated premiums.

CONCLUSIONS AND RECOMMENDATIONS

Capacity building

Based upon our analysis, we have concluded that the insurance sector in India requires extensive technical assistance and training. While there are some barriers and constraints, we believe that most if not all are transitory and will be eliminated as the market matures. USAID also enjoys comparative advantage by being able to call on the numerous institutions in the USA that regulate and develop insurance markets. Some, such as the NAIC, IIF and IIC have already been mentioned. In addition, there are professional organizations such as the Society of Actuaries, Chartered Life Underwriters, Chartered Property and Casualty Underwriters, Life Management Association, etc. that are excellent resources for USAID.

As noted in our introduction, the insurance sector is an essential element of USAID's Strategic Objective Eleven. Even during the period of transition from a fledgling industry to one that is more mature, USAID will be achieving tangible results in building institutions and capacity. USAID will be assisting in preparing the market for full liberalization; will be creating confidence in the insurance sector that currently does not exist; and will be creating institutions that will be steering a more effective mobilization of resources.

Additionally, no economy can modernize without a reliable insurance mechanism – it is essential to managing the risks that must be managed in order to achieve greater economic development.

Finally, the insurance sector is an integral part of the "financial institutions" of a modern economy. Its role as a financial intermediary is no less important that its function as a risk-management intermediator. The function that insurance plays as a financial intermediator has tangible benefit to the development of capital markets and other investment needs of India. Its role as a risk intermediary is essential to any pension reform that will provide for annuity payments to retirees.

USAID's technical assistance should encompass three (3) phases over approximately a five-year period. Note, the following topics are general – the specific activities that could be included are set forth in Section 3.

The first phase – accomplished in the first 18 months to 24 months would be focused on building the basic organization and staff skills of IRDA.

- Assessment of IRDA's organization and staffing and staff rationalization
- A gaps analysis of the laws and regulations
- Training needs assessment
- A thorough review of the procedures used by IRDA and a recommended plan for streamlining and improving efficiency
- Training on risk-based supervision

- Creation of an India-specific Early Warning System
- Preparation of manuals of practice and procedure for all phases of IRDA activities
- Building the IRDA's specialized authority and capacity in the area of health insurance and managed healthcare in terms of legal foundations and training
- Studying and implementing the statutory predicates for a meaningful dispute resolution system to protect consumers
- Diagnostic, action plan and phasing (over a three or four year period) for a comprehensive Indian Insurance Supervision System (IISS)
- Preparation of a regulatory accounting practices and procedures compendium
- Institution of process-based training
- Presentation of insurance-awareness workshops
- Formation of a working group to eliminate the TAC and replace it with a Rating and Statistical Organization (RSO)
- Action plan for instituting an insurance industry-funded casualty actuarial program
- Establish prudential rules for foreign reinsurance
- Attempt liaison with Ministry of Health

The second phase – scheduled around the 18th to 42nd months (and which may involve some continuation of phase one activities) would be focused on building advanced skills for IRDA.

- Creation of models for managed healthcare systems and quality assurance
- Formation of a working group to design an Indian mortality table
- Formation of a working group to design both life and non-life underwriter (risk assessment) certification and require all insurers to have qualified underwriters
- Standards for both upward and downward deviations from Tariffs set by the TAC
- Conduct on-site market conduct examinations
- Oversee on-site financial condition examinations
- Intensive training through interaction with USAID advisors
- Training abroad for advanced students
- Introduction of broader use of IISS
- Mandatory electronic format filing of financial statements of insurers
- Planning of an NBFI strategy and liaison
- Workshops for the industry on designing new products to meet market demands

The final phase – scheduled for around the 36th to 60th months (and which will likewise involve continuing activities from phase one and two) will be focused on instituting modern insurance supervision practices in the IRDA:

- Introduction of a train-the-trainers educational program within IRDA
- Introduction of career development incentives to IRDA staff
- Creation of IRDA's own financial condition inspection unit
- Mandatory on-line filing of financial statements with IRDA
- Continued intensive training of IRDA personnel through interaction with USAID advisors
- Final phases of IISS running.

Recommended Strategic Approach for the Health Insurance Sector

Conditions in India are ripe for the development of health insurance sector. It should follow the opening of the insurance market to competition by private and public insurance companies. High-income and the increasing middle-income segments of the population are already demanding alternative sources of healthcare financing and delivery. Responding creatively to this demand in the near-term will increase the possibilities of the health insurance system to consolidate and to expand to other segments of the population in the mid-term. Although the establishment, institutionalization and consolidation of health insurance take time and effort, it would be wise and advisable to invest now in the foundations of the system. A three-pronged strategy is proposed for USAID investment in health insurance in India to be developed commonly with IRDA over a period of 3-4 years.

A. Awareness and Training. The goals of this strategic component are to disseminate knowledge about health insurance to as many stakeholders as possible and to engage access and participation in a structured and sustained developing industry.

Awareness aims at communicating modern health insurance (purposes, characteristics, advantages and limitations). This includes stimulating healthcare-financing stakeholders, i.e., the State insurance system and the private insurance industry in seeking health insurance licensing, developing basic health insurance products, and marketing. It also involves healthcare providers, particularly those already involved in insurance and managed-care types of activities to participate in a structured system of health insurance. Public and private corporations with self health insurance programs, and community-based programs currently engaged in some type of healthcare financing and delivery should also be involved.

Activities:

- Series of Seminars and Workshops nationwide on issues such as "Fundamentals of Health Insurance"; "Opportunities Offered by the Opening of the Insurance Market in India"; "Role of IRDA in the Development, Regulation and Supervision of Health Insurance", and "Health Insurance Benefits" (2002-2005).

- Series of Seminars and Workshops nationwide on issues such as "Fundamentals of Managed-Care"; "Health Insurance and Managed Care Industries", "Role of IRDA in the Development, Regulation and Supervision of Managed Care", and "Managed Care Benefits" (2002-2005).
- A Round-Table on Public and Private Sectors Participation in Health Insurance (called by IRDA, with the participation of the State insurance system and the licensed private insurance companies) (late 2002).
- Series of Seminars on "Role and Practices of Healthcare Providers in Health Insurance" (2002-2005).
- Training Seminars for Health Insurance Actuaries (2002-2005).
- Training of Health Insurance Intermediaries (agents, actuaries, accountants, lawyers, claim processors, etc) (2002-2005).
- Organization of a National Health Insurance Conference (co-sponsored by IRDA, USAID, The World Bank, DIFD and other donor agencies) to discuss and define a national health insurance program (early 2003).
- A thorough (but practical) Health Insurance Sector Analysis to identify and model the various risk-based financial schemes and managed-care types of delivery for a sound knowledge of current local practices (2002).

B. Legal Framework. The goals of this component are (a) to start as soon as possible the process of research, drafting and discussion of a basic legislative framework for health insurance and managed care. This will provide for the opportunity to revise the current insurance legal system and come forward with a sound, simple, well structured legal framework allowing IRDA for comprehensive regulation; and (b) to revise the legal framework and the means of implementation of essential quality of care mechanisms related to proper licensing and accreditation processes and their adequate implementation. IRDA should lead the following activities:

Activities:

- Series of Workshops on Comparative Health Insurance Legislation (2002) (Parliamentarians, Ministry of Finance, Ministry of Health and Family Welfare, Professional Associations, other stakeholders).
- Research, drafting and discussion of a Health Insurance and Managed Care Law (2002-2003), under IRDA leadership.
- Nationwide Seminars to discuss the draft legislative proposals (2003).
- Study of the Current Situation of Licensing and Accreditation of Healthcare Providers in India (2002-2003).
- Based on the above-mentioned study, review and proposal of the quality of care legal and administrative frameworks in coordination with the Ministry of Health and Family Welfare.

This includes licensing of all types of health care professionals and technicians, and licensing and accreditation of all types of healthcare establishments (2002-2003).

C. Regulatory Structure. The goal of this component is to support and strengthen the institutional capacity of IRDA to perform its regulatory and supervisory roles in health insurance and managed care.

Activities:

- Training of IRDA staff in general issues of health insurance regulation (2002-2005).
- Institution building of a small qualified and interdisciplinary group/unit at IRDA to evolve into an IRDA Health Insurance Regulation department (2002-2005).
- Health insurance company regulations (applicable to all insurance companies, public and private) on issues such as corporate requirements, capital, reserves, investments, accounting, auditing, and reporting (2002).
- Specific regulations on prudential norms and corporate governance for health insurance companies (2002-2005).
- Regulations on health insurance products, their approval and compliance monitoring (2002-2005).
- Regulations on advertisement, sales agents, and transfers from one insurance plan to another (2002).
- Regulation on premiums and contribution collections (2002).
- Regulations on payments of healthcare providers (2002-2005).
- Regulations on customer service, claims and conflict resolution (2002-2005).

The activities included in this three-pronged strategy entail a comprehensive effort by IRDA, the insurance industry, healthcare providers, corporations, community-based programs and the general public, to develop and consolidate the health insurance sector (companies, products, provider networks, and flow of resources). Early success in attracting high- and middle-income populations and large corporations into formal health insurance and managed care, will enable the expansion of the financial and delivery systems to other segments of the population. Economies of scale will allow satisfying increase demand and expanding coverage. The aim of this effort should be to reach 20% of the population after the 3-4 year period, a 100% increase in current health financing coverage.

The following table depicts a possible matrix for sequencing these activities:

RECOMMENDED STRATEGIC APPROACH FOR HEALTH INSURANCE SECTOR DEVELOPMENT					
STRATEGY	**ACTIVITIES**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**
A. Awareness and Training To disseminate knowledge about health insurance to as many stakeholders as possible and to engage access and participation in a structured and sustained developing industry.					
	Series of Seminars and Workshops nationwide on issues such as "Fundamentals of Health Insurance"; "Opportunities Offered by the Opening of the Insurance Market in India"; "Role of IRDA in the Development, Regulation and Supervision of Health Insurance"; and "Health Insurance Benefits" (2002-2005).	X	X	X	X
	Series of Seminars and Workshops nationwide on issues such as "Fundamentals of Managed-Care"; "Health Insurance and Managed Care Industries"; "Role of IRDA in the Development, Regulation and Supervision of Managed Care"; and "Managed Care Benefits" (2002-2005).	X	X	X	X
	A Round-Table on Public and Private Sectors Participation in Health Insurance (called by IRDA, with the participation of the State insurance system and the licensed private insurance companies) (late 2002).	X			
	Series of Seminars on "Role and Practices of Healthcare Providers in Health Insurance" (2002-2005).	X	X	X	X
	Training Seminars for Health Insurance Actuaries (2002-2005).	X	X	X	X
	Training of Health Insurance Intermediaries (agents, actuaries, accountants, lawyers, claim processors, etc) (2002-2005).	X	X	X	X
	Organization of a National Health Insurance Conference (co-sponsored by IRDA, USAID, The World Bank, DIFD and other donor agencies) to discuss and define a national health insurance program (early 2003).		X		
	A thorough (but practical) Health Insurance Sector Analysis to identify and model the various risk-based financial schemes and managed-care types of delivery for a sound knowledge of current local practices (2002).	X			

RECOMMENDED STRATEGIC APPROACH FOR HEALTH INSURANCE SECTOR DEVELOPMENT					
STRATEGY	**ACTIVITIES**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**
B. Legal Framework Research, drafting and discussion of a basic legislative framework for health insurance and managed care; revision of current insurance legal system towards a sound, simple, well structured legal framework allowing IRDA for comprehensive regulation; revision of the legal framework and the means of implementation of essential quality of care mechanisms (licensing and accreditation processes and their implementation).					
	Series of Workshops on Comparative Health Insurance Legislation (2002-2003) (Parliamentarians, Ministry of Finance, Ministry of Health and Family Welfare, Professional Associations, other stakeholders).	X	X		
	Research, drafting and discussion of a Health Insurance and Managed Care Law (2002-2003), under IRDA leadership.	X	X		
	Nationwide Seminars to discuss the draft legislative proposals (2003).		X		
	Study of the Current Situation of Licensing and Accreditation of Healthcare Providers in India (2002-2003).	X	X		
	Based on the above-mentioned study, review and proposal of the quality of care legal and administrative frameworks in coordination with the Ministry of Health and Family Welfare. This includes licensing of all types of health care professionals and technicians, and licensing and accreditation of all types of healthcare establishments (2002-2003).	X	X		

RECOMMENDED STRATEGIC APPROACH FOR HEALTH INSURANCE SECTOR DEVELOPMENT					
STRATEGY	**ACTIVITIES**	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**
C. Regulatory Structure To support and strengthen the institutional capacity of IRDA to perform its regulatory and supervisory roles in health insurance and managed care.					
	Training of IRDA staff in general issues of health insurance regulation (2002-2005).	X	X	X	X
	Institution building of a small qualified and interdisciplinary group/unit at IRDA to evolve into an IRDA Health Insurance Regulation department (2002-2005).	X	X	X	X
	Health insurance company regulations (applicable to all insurance companies, public and private) on issues such as corporate requirements, capital, reserves, investments, accounting, auditing, and reporting (2002).	X			
	Specific regulations on prudential norms and corporate governance for health insurance companies (2002-2005).	X	X	X	X
	Regulations on health insurance products, their approval and compliance monitoring (2002-2005).	X	X	X	X
	Regulations on advertisement, sales agents, and transfers from one insurance plan to another (2002).	X			
	Regulation on premiums and contribution collections (2002).	X			
	Regulations on payments of healthcare providers (2002-2005).	X	X	X	X
	Regulations on customer service, claims and conflict resolution (2002-2005).	X	X	X	X

Considerations for a Training Needs Assessment

As a regulatory institution, IRDA needs a clear understanding of its various roles (what to regulate; how to regulate; what to supervise; how to supervise; what to control; and how to control). Given the nature of the new insurance industry in India, training for IRDA management and staff needs to include modern concepts and techniques, procedures and practices that are consistent with international developments in insurance.

At the high management level, training should focus on the nature and expectations of an insurance regulator of both private and public sectors. IRDA will eventually have to regulate insurance-type schemes (even those with different names) managed by micro-finance institutions, trade unions and non-governmental organizations. IRDA also hopes to regulate pensions. Further, insurance (and pension funds and pension asset management companies) is a component within the larger framework of Non-Banking Financial Intermediaries.

At the staff level, training should be comprehensive and take place at all levels. For instance, regarding regulations training on comparative sources of inspiration, international standards, drafting, transaction costs implications for the industry, implementation directives; administrative interpretation, and record of inquires and replies.

The training program should be systematic for insurance and eventually for pensions. It should be phased in a mid-term program of increasing levels of complexity. IRDA needs to obtain support for its training needs from international and bilateral financial and donor agencies, but also from institutions such as the NAIC, International Association of Insurance Supervisors, IIF and IIC.

It is hoped that the programs in the NIA and IIM at Bangalore will be outpacing the market and will be developing useful training programs for regulators and industry alike.

There is little that USAID itself can do to promote the broadening and deepening of the market. However, IRDA with the proper technical assistance from USAID can serve in that capacity since its charter includes the development of the insurance sector.

The major role that USAID can play would be supporting IRDA's efforts to promote the creation of a Rating and Statistical Organization by the insurance companies.

Also, targeted workshops for the IRDA and the industry on products designed to meet market needs would be useful.

ANNEX ONE

ORGANIZATIONS VISITED

USAID – Washington, DC including Asia and Near East Bureau
National Association of Insurance Commissioners – Washington, DC
International Insurance Federation -- Washington, DC
International Insurance Council -- Washington, DC
International Monetary Fund -- Washington, DC
International Finance Corporation – New Delhi
USAID/India – New Delhi
- Mission Director
- Deputy Mission Director
- Office Director, Program Development and Economic Growth
- Office of Population, Health and Nutrition
- Office of Social Development

Chairman and board members, Insurance Regulation and Development Authority
Joint Secretary to Government of India, Ministry of Finance
Confederation of Indian Industry
Employees State Insurance Corporation
New Indian Assurance Company
Actuarial Society of India
Institute of Chartered Accountants of India
Institute of Insurance Surveyors and Adjusters
Tariff Advisory Committee
Life Insurance Corporation of India
ICICI – Prudential Life Insurance Company
HDFC – Standard Life Insurance Company
Dabur – CGU Life Insurance Company
National Insurance Academy
Indian Institute of Management at Bangalore
Sanghami – Rural Financial Services
Myrada – Micro-Finance
Basix Micro-Finance
Share Microfin, Ltd.

ANNEX TWO

INDIAN HEALTH SECTOR ANALYSIS

India reached a population of one billion in the year 2000. A decline in the fertility rate is likely to show a gradual decrease in population growth. The demographic profile of India is that of a young population with 33 percent below age 15. However, people over 60 years of age (around 6.3 percent) are increasing. About 71.5 percent of the population (716 million inhabitants) lives in rural areas. The number of women per 1,000 males is 960. The infant mortality rate is 67.6/1000 of live births under one year.[4]

Although health conditions and health status have improved dramatically since Independence, the remanding problems are monumental. While a health transition takes place in the mid and upper echelons of society with increasing chronic and degenerative diseases, the vast majority still suffers from widespread poverty-related diseases, including infectious, communicable, and reproductive-related diseases, and under- and mal-nutrition. HIV/AIDS add to these problems with epidemic proportions.

Healthcare facilities. The Indian healthcare delivery system is a public/private mix. Public healthcare is a shared responsibility by the State, central and local governments. State and local governments participate with 75 to 90 percent of the public healthcare expenditure. There are wide variations among states and within states.

A complex array of public healthcare facilities (hospitals, clinics, dispensaries, health centers, laboratories, etc.) provides in-patient care for around 80 percent of the population. Vertical programs of the Ministry of Health and Family Welfare (MOH) deal with tuberculosis, malaria, leprosy and HIV/AIDS. Most public healthcare facilities are under-funded and under-staffed. Extensive networks of healthcare facilities are owned and managed by the two mandatory State insurance schemes, the Central Government Health Scheme, CGHS, and the Employees State Insurance Corporation, ESIC. ESIC's hospital network is the largest in the country. Public employer-based schemes such as railways, plantations, mining and universities, have their own closed healthcare networks.

In spite of the large public healthcare infrastructure, access, effectiveness and quality of care are considered low. Limited and declining overall public investment in health and structural constraints in the public healthcare delivery system limit its effectiveness and has a negative impact on quality. Further, access is restricted by pervasive informal payment required at the point of service. Primary healthcare is considered to be ineffective due to insufficient penetration and lack of depth. People access hospitals without referrals from the primary healthcare level.

Private healthcare facilities of all sorts have flourished in the last decade, including hospitals of all sizes and specialties, diagnostics laboratories, and pharmacies targeting the middle and upper levels of income. A number of private hospitals are recognized centers of excellence in various specialties. Large private employers also own healthcare facilities to service their self-insured employees, although contracting with private providers is also common. The private sector

[4] National Family Health Survey-II, Health and Family Welfare, India, 1998-1999, International Institute for Population Sciences, Mumbai, November 2000.

dominates in outpatient care and in small healthcare facilities. Unfortunately, this sector is largely unregulated. Accreditation of healthcare facilities by the MOH is considered a token and bureaucratic process. Monitoring, supervision and control, and re-accreditation are largely absent.

Healthcare providers. In India, western medicine coexists with various forms of traditional or alternative medicine. Regrettably, private medical practitioners both in western and traditional medicine are largely unregulated and expanding. Licensing and registration processes are not systematic. Monitoring, supervision and control of these practitioners is also largely absent. The majority of the people seek private providers for outpatient care. Since outpatient visits to public facilities involve some kind of payment, there is a preference for the private provider as payment is viewed as an implicit contract for service that brings with it better attention.

The deficiencies and unregulated supply of healthcare provision, both on the part of healthcare facilities and practitioners are major concerns in the Indian health sector, adversely impacting its competence and the quality of care. This situation will be a major factor in the development of health insurance in that it may complicate the purchasing of healthcare services. Health insurance companies will have to develop networks and impose standards to ensure adequate and professional treatment and minimum quality of care.

Healthcare Expenditures. Most documents on the Indian healthcare system and its financing, as well as those interviewed, refer to 6 percent of GDP (currently around US$400 billion) as the figure for total health care expenditure.[5] It is likely that this figure will be revise to 4.5 percent of GDP (now around US$ 18 billion) or US$18 per capita.[6] Public healthcare expenditure is at present put at less than 1 percent of GDP. This level of healthcare expenditure is considered very low. The average expenditure level for low and middle-income countries is 5.6 percent. However, the basic distribution of healthcare expenditure has not changed. What is alarming is the decline in public expending, mainly affecting primary healthcare and maintenance and supply of public hospitals.

Table 1. INDIA: HEALTHCARE EXPENDITURES
(2000 GDP estimate: US$400 billion)

Category	*1993 Estimates*			*2001 Estimates*		
	%	*US Dollars*	*% GDP*	*%*	*US Dollars*	*% GDP*
Out-Of-Pocket	75	18,000,000,000	4.5	75	13,600,000,000	3.4
Pay-roll taxes	3	800,000,000	0.2	5	800,000,000	0.2
Public sources	22	5,200,000,000	1.3	20	3,600,000,000	0.9
TOTAL	100	24,000,000,000	6.0	100	18,000,000,000	4.5

[5] The 6% figure has been borrowed from the 1993 World Development Report on "Investing in Health", and it is based on 1990 estimates.
[6] The forthcoming Report is on Better Health System's for Indians' Poor.

Public expenditure needs to increase at least to levels in previous years. The allocation of public healthcare resources should be directed to primary healthcare, public hospitals, and diverted from subsidizing mid- and high-income individuals, particularly public servants in the central government. The high level of Out-of-Pocket expenditures indicates that the public healthcare system is far from being free of charge, due to required formal and informal payments. All levels of the population, including the poor, resort to private paid outpatient care. Out-of-Pocket financing at the point of service is an inefficient manner of healthcare financing, particularly for the most vulnerable.

This inorganic healthcare market offers ample potential for the development of health insurance. Channeling private healthcare through insurance will require creativity with appropriate insurance products for different segments of the population involving control of informal payments and the offering of a relatively comprehensive array of healthcare services.

Healthcare Coverage. Roughly over 10 percent of the population is covered by public health insurance schemes, social security and employer-based self insurance. If one takes the total workforce and uses the information available under public sector coverage of healthcare financing and provision, the actual public sector coverage is merely around 5 percent of the workforce. This means that there is ample room for the development of a private sector health insurance industry in tackling the workforce market.

Table 2. INDIA: PUBLIC SECTOR HEALTHCARE COVERAGE OF THE WORKFORCE
(Based on an estimate of a workforce of 320 million)

1. MANDATORY	Workforce	Percent
1.1. PUBLIC SECTOR HEALTH INSURANCE. CENTRAL GOVERNMENT HEALTH SCHEME (CGHS).	Around 1.5 million workers and dependents (total coverage 4.5 million with an average of 3 dependents)	0.46%
1.2. SOCIAL SECURITY. EMPLOYEES STATE INSURACNE SCHEME (ESIS)	Around 6.6 million workers and dependents (total of 30 plus million with average of 5 dependents).	2.06%
2. VOLUNTARY		
2.1. MEDICLAIM	1.8 million	0.56%
2.2. DISEASE RESTRICTED.	No data available, but seems extremely limited	
3. SELF-INSURANCE		
3.1. PUBLIC SECTOR UNITS.	Around 5 million workers and dependents (total coverage around 25 million with an average of 5 dependents)	1.56%
Total		4.64%

The remainder of the population (90%) relies on the public healthcare sector and increasingly on the ambulatory and in-patient services provided by the private sector. Around 80 percent of outpatient care is provided by the private sector.

There are significant variations in healthcare coverage from state to state and within states in the Indian Union. This is important for the health insurance industry. Strategies for penetrating and

deepening the insurance markets will have to be tailored to the economic, social and infrastructure particularities of various states and within states.

Basic healthcare statistics are considered poor and inconsistent. Appropriate information on morbidity, mortality, clinical outcomes, technology, types and volume of cases, and service indicators, are essential for the healthcare system and for the development of health insurance. The lack of adequate, chronological and sustained data could be an impediment for the health insurance industry in business planning, rates determination, and in designing insurance products. Most likely, insurance companies would have to develop their own data, hopefully under standardized forms required by IRDA.

There are major problems related to equity, quality of care, and accountability in both the public and the private sectors. The MOH is considered inefficient in its role as supervisor of the quality of care (licensing, accreditation) and in setting and implementing clinical and managerial protocols.

Proper licensing and accreditation processes duly implemented are critical factors for the development of sound healthcare systems. Their absence will affect the development of proper health insurance. The burden of restructuring the healthcare system, at least partially, would be borne by insurance companies while building up their own networks, standards and systems.

The public sector manages a complex system of health insurance, that includes mandatory closed health insurance for central government employees, a mandatory social security scheme for low income industrial workers, two voluntary open limited health insurance schemes run by the two State Insurance Companies, and self-insurance at selected State-owned enterprises and other entities (public sector units). The entire system covers only around 45 million people, or 4.5 percent of the population.

Table 3. INDIA: PUBLIC SECTOR HEALTH INSURANCE SCHEMES. Comments.	
1. MANDATORY	
1.1. PUBLIC SECTOR HEALTH INSURANCE. CENTRAL GOVERNMENT HEALTH SCHEME (CGHS):	Provides comprehensive medical care to central government employees and families. A privileged and closed health insurance scheme essentially financed by the Central Government with minimal contributions by the beneficiaries. Covering around 4.5 million workers and dependents, it is reported to have problems of access and of quality. There is a tendency to abuse with excessive use of hospital-based specialist consultations. Long waiting lists, inadequate supplies of staff, medicines and equipment and less that desirable hygienic conditions at healthcare facilities leads to extensive use of private providers at fee-for-service reimbursement and selective treatment abroad.
1.2. SOCIAL SECURITY. EMPLOYEES STATE INSURANCE SCHEME (ESIS):	Compulsory social security benefit for low income workers in the formal sector. Lower income only: basic monthly salary of less than Rs 6.500.Covering around 35 million beneficiaries, it provides preventive and curative care as well as cash benefits. Health promotion and health education are components of the healthcare package. Primary health care is financed through capitation and it is reported to be functional. Problems were reported with financing and management of hospitals at the state level.
2. VOLUNTARY	
2.1. MEDICLAIM.	Restricted healthcare product offered by the (State) General Insurance Company and its subsidiaries. Restricted to hospital and domiciliary care, is the antithesis of comprehensive health insurance excluding preventive and ambulatory care. An indemnity-type of insurance, it has a widely acknowledged ill record with late and partial reimbursements for the upfront payment to providers by beneficiaries. The perception is that Mediclaim is ineffective, and unsatisfactory for provides and beneficiaries. Its low coverage of only 1.8 million indicates that this scheme should not be the model for health insurance.
2.2. RESTRICTED INSURANCE.	Offered by the (State) Life Insurance Corporation (LIC) on selected dreaded diseases. Very limited form of health insurance, it follows the general features of Mediclaim as indemnity-type insurance. Covering only a number of diseases it does not seem to imply a significant alleviation of financial risk. Policies restricted to a certain number of diseases. No data was provided on coverage.
3. SELF-INSURANCE	
3.1. PUBLIC SECTOR UNITS. SELF INSURANCE	Comprehensive healthcare and cash benefits offered by large state-owned entities (public sector units) to its employees (plantations, railways, mining, defense and security forces, and universities). Healthcare facilities and salaried providers are part of total company operating costs, and it is difficult to assess cost-effectiveness and efficiency. Possibly high administrative costs should lead to polling resources and rationalize costs. Coverage is estimated at around 25 million people.

The main outstanding issues relate to the questionable cost-effectiveness, efficiency and quality of care of the public sector schemes. With the exception of the ESIS that reaches a significant portion of low income workers and families in the formal sector as a social security system, the other schemes do not seem to be cost-efficient and their coverage is minimal in relation to their burden to the public treasury and population covered.

There is ample room for reforming these schemes. Indeed, in doing so there is a potential for private health insurance and managed care organizations (MCO) to pool resources and organize a better and more effective and quality provision of healthcare.

Additional issues that would have to be tackled in the future if public insurance schemes come under the full regulatory and supervisory authority of IRDA include:

- Real cost accounting to determine the actual cost (explicit and hidden) of public healthcare, to expand services and coverage.
- Reforming CGHS to expand coverage to all civil servants, central and state.
- Expanding the coverage of ESIC to groups of informal workers (rickshaws drivers, street vendors, and others); and raising the eligibility ceiling of ESIC to expand coverage. ESIC management is already planning to increase the eligibility ceiling from Rps. 6,500 to perhaps Rps. 10,000 or 12,000. ESIC has the installed capacity and the resources to accomplish this task. This expansion has a potential of at least 10 percent of actual coverage, some 3 to 5 million people. ESIC is already planning to encourage these groups to organize and seek insurance protection from ESIC.
- Studying the possibility of merging CGHI and ESIC, and some public self-insurance schemes into a unified social security system for the public sector.
- Limiting the expansion of Mediclaim as a health insurance product. It is widely considered inefficient and has already given a bad name to health insurance with dissatisfaction of providers and beneficiaries due to late and partial reimbursements, and claims abuse and fraud.
- Improve the efficiency and effectiveness of public insurance schemes by pooling resources, rationalizing in-house provision of healthcare, and expanding contracting of personal and non-personal services.

In spite of the fact that formal private healthcare insurance is yet to develop, there is no question that there are many schemes currently in the market, from company-based self-insurance to incipient and informal managed-care-type of financing and provision of healthcare. The flourishing of high-tech healthcare facilities targeting the upper and mid levels of income usually comes along with pre-paid or similar financial incentives.

Regrettably, information is scarce, and there is a need for research into the various models currently in place. This will help IRDA and the potential healthcare insurance industry in assessing the particularities of the Indian market.

Many of the resources currently used by public and private corporate self-insurance schemes, could be put to better use and rationalized by insurance companies and MCO through pooling of financial resources and through select network of providers. Likewise, the existing corporate healthcare can be maximized with better use of the installed capacity, selling of services, and integration into networks. This could result in cost-efficiency and expansion of coverage and services.

Table 4. INDIA. PRIVATE SECTOR HEALTH INSURANCE SCHEMES. Comments.	
1. SELF-INSURANCE	
Comprehensive healthcare and cash benefits offered by large PRIVATE entities to its employees and dependents.	Similar to the case of public sector units' self health insurance, many large private companies have their own healthcare facilities and salaried providers to provide comprehensive healthcare, reimbursements and cash benefits to employees. There is no data on costs and it is difficult to assess cost-effectiveness and efficiency. Possibly high administrative costs should lead to polling resources and rationalize costs, offering a vast window of opportunities for the development of private health insurance and MCO to serve this segment of the population and alleviate the cost and burden of company owned healthcare and uncontrolled reimbursements. There are no statistics on population covered, but industry estimates put it at around 5 million.
2. COMMUNITY-BASED INSURANCE	
A variety of healthcare-related services provided by non-governmental organizations and micro-financing institutions mainly to the rural poor and to some of the urban disadvantaged.	Although not accounting for much of healthcare provision, these schemes however modest mean the only access to some kind of preventive and curative care for a segment of the poor. A realistic account put the population served at around 1% or 40 million.
3. HEALTH INSURANCE	
3.1. Health insurance proper	On the financing side, health insurance it is yet to develop with the licensing of health insurance companies (none yet), the assessment of the potential market, design of insurance products, and adequate but not cumbersome regulations. On the provision side, reliable and quality healthcare facilities and providers are required. The highly developed network of private hospitals and laboratories of excellence targeting the affluent could be a start. The challenge for the regulators and for the industry is the expansion of health insurance. Although there is an acknowledged potential market, there is reluctance on the part of private insurance companies to enter into the market so far.
3.2. Managed care	There are accounts of a variety of models use by private hospitals to attract a constituency with pre-paid mechanisms that need to be researched, confirmed and systematized. These schemes could serve as the base for the development of managed care by pooling resources and systematizing the infrastructure and use of use of consultations, ambulatories, laboratories, and referrals to secondary and tertiary levels of care.

Among our considerations were a number of issues ancillary to the main themes of technical assistance. For example, passing of the IRDA Act ended the State monopoly of insurance in India and opened the door for the involvement of private insurance in which it should become a public and private mix. For a sound, fair and competitive insurance market to develop, IRDA needs to subject all public and private insurance companies under its regulatory and supervisory authority, with no exceptions.

This is particularly important in the case of health insurance and managed care. All insurance companies, and all operations that entail financial risk transfer related to healthcare should be under the jurisdiction of IRDA. Currently, the State General Insurance Company offers Mediclaim under its own regulations; the Life Insurance Corporation of India offers disease-restricted insurance under its own Act and regulations; the Employees State Insurance Company offers healthcare as part of its social security mandate for low-income workers in the formal sector; corporate self-insurance healthcare schemes operate under company law and have not been subject to IRDA regulation. The same is pertinent concerning healthcare financial risk management schemes by micro-finance entities and non-governmental organizations.

There is a clear perception that one of the major problems in the healthcare sector is the unregulated and low quality of providers. It seems obvious that the MOH needs to improve in the licensing and accreditations procedures to ensure minimum quality of care. Licensing of healthcare professionals including physicians, nurses, technicians both in western and traditional medicine, and accreditation and re-accreditation of all healthcare facilities, including hospitals, clinics, ambulatories, pharmacies, laboratories, and other types of healthcare providers need to follow modern procedures and should be a priority.

Since adequate supply of healthcare providers is critical for health insurance and managed care, IRDA needs to establish formal coordination mechanisms with the MOH to support urgently needed efforts to upgrade licensing and accreditation, and to require and allow only licensed healthcare professionals and accredited healthcare facilities to be used by health insurance and managed care systems.

Self-Regulatory Organizations (SRO) like the Indian Medical Association, the Medical Council of India, and other professional associations such as those for pharmacies, laboratories, nurses, etc., need to play a key and active role in standardizing and upgrading the practicing standards and procedures with strict qualification requirements and with continuous education programs for re-licensing. These procedures should be duly designed, properly monitored, and supervised.[7] Consumer groups and issue-specific associations such as cancer, diabetes, and leprosy societies, should also play role in consumer awareness and in contributing to demand the raising of delivery standards of care.

There is an obvious role for IRDA as the insurance regulator in intervening and intermediating with the MOH and with various self-regulatory organizations in the healthcare sector (councils,

[7] A recent initiative for continuous medical education by the Indian Medical Association has been criticized for lack of proper design and absence of monitoring capacity.

societies, and associations) to introduce fundamental reforms in the healthcare delivery system to enhance quality of care and to support the development of the health insurance industry.

At present, public, private business and non-governmental sectors, appear to be operating various schemes dealing with financial risk transfers that could and should be considered as health insurance, as well as various pre-paid schemes that could and should fit within a definition of managed healthcare. Combinations of health insurance and managed care could be possibly found in both public and private corporate self-insurance schemes (see Annex 1). The non-governmental sector, and to some extent some micro-finance operations that include some health protection are also forms, albeit incipient, of health insurance. Different names given to these schemes should not prevent IRDA from regulate them in the near future under a conceptual definition of health insurance and managed caring.

It would be most important to conduct research into these various schemes to model them. These models could serve the health insurance and managed healthcare industries for a good understanding of the current informal markets, and to design insurance products accordingly.

Private insurance companies and MCOs can play a role in pooling resources for the purchasing of healthcare services from both the private sector and the public sectors. The private sector would have to devise new and comprehensive healthcare insurance product and avoid repeating the ill-reputed Mediclaim experience.

A rough estimate of the potential market for private health insurance and managed care could be put between 200 and 300 million people. This is consistent with international experience where private health insurance covers around 25 percent of the population. In the case of India, managed care could have a positive impact in financing hospital-based care in a more systematic and efficient manner than what it is currently done through various non-institutional mechanisms. Healthcare insurance can capture and service many of the public and private corporate self-insurance schemes.

This rapid assessment of healthcare insurance in India validates the following:

A. Key Policy Issues.

- Current public healthcare insurance schemes are fragmented, and operating with limited, if any, coordination, and with very low coverage. There is no general strategy to consolidate the various schemes, to pool resources and to rationalize and upgrade the vast networks of public healthcare facilities.
- All insurance schemes public and private, regardless of the existence of statutory acts, should fall under IRDA licensing, regulation and supervision and subject to the same operating terms and conditions in a fair, competitive and regulated environment.
- All privileges and subsidies favoring public insurance companies should be eliminated.
- Public subsidies for premiums for the disadvantaged should be made available to public and private insurance companies. There is an urgent need for reliable data on unit costs, operating

costs, explicit and hidden subsidies to measure the financial effectiveness and efficiency of the various healthcare financing and delivery schemes currently in place for a full financial and operational assessment.

- A comprehensive national health insurance and managed care strategy with proper definitions is absent.
- Designing a policy towards public hospital autonomy is an issue that should be considered by Government to allow and encourage the purchasing of public services with private financing and maximize the use of installed capacity.

B. Key Institutional Issues

- IRDA needs to improve its general institutional capacity building with competent staff and incorporating private sector experience.
- IRDA should establish a health insurance department with well-designed functions and appropriate staff.
- Training of human resources at all levels in the public and private sectors in health insurance and managed care is indispensable. Training should include public and private insurance companies, IRDA, MOH, professionals such as lawyers, accountants, medical doctors, nurses, pharmacies, hospital administrators, etc.
- There is an urgent need for reliable data on unit costs, and operating costs, explicit and hidden subsidies to measure the financial effectiveness and efficiency of the various healthcare financing and delivery schemes currently in place for a full financial and operational assessment.
- Current private healthcare insurance schemes are limited and provide coverage for a limited portion of the population. Several outstanding structural constraints could retard and limit the introduction of properly regulated, formal and efficient health insurance and managed care systems, mainly dealing with the competence and quality of the supply of healthcare delivery.
- There are accounts of various non-institutionalized mechanisms for financing and delivery of healthcare that need to be researched, modeled and incorporated into the stream of institutional healthcare insurance and managed care. These mechanisms should be very useful in developing the Indian healthcare insurance market.
- IRDA, in coordination with the MOH and other public and private institutions, need to promote the development of national healthcare statistics.

C. Key Regulatory Issues

- A comprehensive, harmonized codification of insurance laws into a General Insurance Act, with chapters for IRDA, insurance companies health insurance and managed care, etc., could be most useful.

- IRDA should issue a regulation defining health insurance and managed care and setting basic requirements for its performance.
- IRDA should draft, discuss and issue a whole set of regulations related to health insurance and managed care mandatory to all public, private, micro-finance and non-governmental organizations involved in health insurance and managed healthcare activities. IRDA should indirectly regulate the application of proper standards and procedures by providers engaged by health insurance companies and MCO.
- IRDA should require all insurance companies engaged in health insurance should be required to hire and contract with health care professionals (physicians, nurses, pharmacists, laboratory technicians and others) subject to mandatory and strict licensing, continuous education and periodic re-licensing requirements, and with healthcare facilities (hospitals, clinics, laboratories, pharmacies, etc.) subject to mandatory and strict licensing/re-licensing and accreditation/re-accreditation procedures.

IRDA is called to play a complex and fundamental role in regulating and supervising healthcare insurance and managed care. To accomplish these functions properly, IRDA needs to build capacity, competence and credibility as a sound, fair and able regulator. Technical assistance and training are essential to achieve this competence. There is an ample potential market for the development of healthcare insurance and managed care with a promising expansion of coverage at all levels of income with cost-effectiveness and enhanced quality of care. This market will develop if structural constraints are leveled, proper but not burdensome regulations is put in place, all players are required to abide by the same rules and regulations, and prices are left to the market to be determined under fair competition.

The current healthcare system and the financing and delivery of healthcare are fragmented and institutionally reaching only 10 percent of the population. The affluent have access to first class, high tech healthcare. The vast majority of the population relies on low quality, public healthcare and mainly on private healthcare on an out-of-pocket basis at the point of service, usually by unlicensed professional and non-accredited establishments. There is an unquestionable need to properly develop a fair and competitive healthcare insurance market to expand accessibility, coverage, cost-effectiveness and quality of care. This should be part of a resolute, coordinated and systematic national policy to develop insurance and the non-banking financial intermediaries (NBFI) sector.

The recommendation is to develop a broad and mid-term program of technical cooperation and training to sustain the development of the health insurance and managed health care industries in India. Investment in technical assistance and training is the most rewarding activity to ensure the development of a well-regulated, fair and competitive market, mobilize resources and expand quality coverage.

ANNEX THREE

FURTHER INFORMATION ON CURRENT PENETRATION OF INSURANCE PRODUCTS

India is a developing economy that offers a vast insurance market with its population in excess of 1 billion. Demographic indicators reveal that 25 percent of the population represents high and middle income groups and the balance consist of low income, poverty and below poverty (BLP) classifications. Great strides are being undertaken by the government, private sector and NGOs in efforts to close these economic gaps. Certain of these programs are aimed especially to reduce the proportion of the BLPs and in the enhancements of activities that will grow the numbers of people the middle class.

The insurance industry was under the monopoly of five (5) state-owned institutions consisting of four (4) non-life companies and one (1) life insurer. Additionally the General Insurance Corporation Ltd. (GIC), another state-owned company, acts as the principal reinsurer of the industry. Without competition, development of the national insurance market has been proceeding at a slow pace. As a result, consumerism to insurance products have not been developed nor pursued as an industry mission.

Approximately 75 percent of the population belongs to the economically "rural" and "social" ("economically deprived") sector. Industry practitioners agree that insurance awareness and responsiveness in this sector is minimal and in a good number of the nation, nil. India's laws and policy legislations require the development of a sustainable national insurance growth and mandate insurance companies to reach out and provide insurance coverage to the economically deprived sector in a effort to broaden and deepen insurance product penetration.

Current regulations define what constitutes "rural" and "social" sectors. We find no reason to argue the wisdom of the present legal definition and/or classification.

The insurance industry recently opened its doors to private ownership. Despite the beginnings of liberalization of the industry and the consequential entry of privately owned enterprises, the market remains to be dominated by the state-owned companies. This dominance will continue considering the enormous asset and reserve bases and vast distribution networks these companies established during all the years of monopolizing the industry. This dominance is further reinforced by the fact that the liabilities of the state-owned Life Insurance Corporation (LIC), and in the same token all the state-owned insurers, are guaranteed by the Government of India.

It is not easy to perceive that current and future regulations of the insurance industry will reduce its focus on the dominance of the state-owned companies. On the other hand, we have every reason to believe that privately owned insurers and prospective investors are aware of this environment and that they are adequately apprised of the nature and the level of playing field in which they are to operate and survive. We can only hope that regulations shall be most transparent, unprejudiced and fair especially as the industry shapes itself as a free market during these transitory years. Encouragingly, the privately owned insurers with whom we have visited echo the common confidence that, over time, the IRDA will counter-balance the private sector's inherent disadvantages vis-à-vis the current public sector environment.

In assessing the efficacy to which the industry is making efforts to reach out to India's economically deprived class, the team devoted much time and effort assessing the degree of national insurance awareness and learning the existing systems of product distribution, the product mix, and after sales services as they impact this market. We gave particular emphasis on the rural and social sectors. The mainstream product accessible to this sector, understandably, is group insurance that is accessible to the labor and social (protected) groups.

ANNEX FOUR

FURTHER DISCUSSION OF EDUCATION, TRAINING AND RESEARCH

National Insurance Academy (NIA). Established in 1981 by the Government of India and financed by the (State) Life Insurance Company of India. It has excellent facilities in a manicured campus. Most, if not all, of the faculty is comprised of practitioners with experience with State insurance companies, mainly at LIC. NIA claims to be partially self-sufficient. NIA provides formal training and offers certificates to managers and executives in the State insurance system. NIA officials expressed an interest in servicing the entire insurance industry. However, there was some reluctance for expanding training leading to certificates because of the fear that graduates may go to the private insurance sector. This contradiction is illustrative of the difficulties that traditional training centers funded, financed, staffed, and dedicated to the State insurance companies will have in adapting to a new insurance environment. Not surprisingly, some people at NIA mentioned that they see no differences between state and private insurance.

NIA should be prepared for a possible lack of interest in its training services by the private sector. It is possible that most of its faculty and the current curriculum would not be suitable for the type of training that foreign insurance companies have already developed for their actual and potential staff. NIA should try to update its training with a fresh influx of private sector concepts and procedures. Given NIA's financial dependence on LIC, this approach may not be feasible. NIA might end up fulfilling its current role of trainer of staff for the State insurance companies. However, at least the use of the infrastructure should be considered by the private sector for training programs of their own cadres.

Insurance research has a long-standing tradition in India. There are many papers published by various institutions involved in training and education. Understandably, insurance research was limited and financially dependent upon State insurance companies. Research papers are largely descriptive, based on documents or secondary information, and centered in the experience of the State insurance companies during the State insurance monopoly (1972-1999).

References to the pre-monopoly times when there was a private insurance industry in India are largely irrelevant in today's insurance environment. The insurance industry has undergone profound and innovative changes in the last ten or so years all over the world. The development of the new insurance industry in India brings with it a large demand for research. Research areas could include:

- Inventory and description of all current formal and informal insurance schemes in the market.
- Inventory, description and modeling of all health insurance-related schemes that involve (a) transfers of financial risk for healthcare expenses and (b) managed-care type of healthcare financing that does not involve mere reimbursements. This research should include all what is conceptually health insurance or managed care provided by the public sector, the private sector, regardless of what the schemes are called.
- Insurance market studies and market simulations.
- Insurance cost analyses, particularly in the public sector.

- Insurance practices (however they may be called) used by micro-finance institutions, trade unions and non-governmental organizations.
- State subsidies.
- Valuation of insurance portfolios.
- Asset valuation of investments by insurance companies.
- Solvency studies of public and private insurance companies.
- Corporate governance and disclosure practices by insurance companies.
- Data banks and financial and demographic statistics (mortality and morbidity).
- Population income surveys.
- Insurance needs surveys.

IRDA should establish it own high level Research Department.

2.3. Education

At the university level, given the actual and potential importance of insurance in the Indian economy, the subject matter should be incorporated into the curriculum of various professions, for example, in law, economics, business administration and applied mathematics for actuaries. Present courses on insurance should undergo a profound revision, incorporating the new legislation on insurance, the nature and role of IRDA, the content and implications of IRDA regulations, the actual status and prospects for the insurance market, comparative insurance legislation and regulation, World Trade Organization standings on insurance and European Union insurance standards.

Indian Institute of Management Bangalore (IIMB). One of the several Institutes of Management in India, it was established in 1973 as part of the Government's commitment to the development of local science and technology. With an impressive and modern campus, IIMB is considered one of the leading business schools in India. It also has a faculty with academic degrees from local and reputed foreign universities.

Forecasting demand for training in insurance, IIMB has established a Center for Insurance Research and Education. The Center is in an incipient stage with only one faculty member in charge of its development. The objective of this Center is to engage in research and consultancy; developing teaching materials, organizing workshops and seminars, conducting management programs for practitioners, and preparing graduate management graduates for insurance and pension businesses. In July 2001, it organized with IRDA the 5th Asia Pacific Risk and Insurance Association Conference at IIMB.

Educational establishments like the IIMB can play a valuable role incorporating insurance as part of their curricula. However, one must remember that insurance is a business conducted through the continuous expansion, refinement, and assessment of risk management. State regulations and self-regulatory standards play a significant, if not critical role. Practices, with procedures,

manuals, and continuous managerial and marketing skills are non-substitutable. Therefore, the role for formal educational establishments in training insurance companies' staff is rather limited. Insurance is a case in which the industry itself undertakes education and training quite successfully. This does not mean that there would be no cooperation and joint educational and research endeavors between the industry and educational establishments. The suggestion is quite to the contrary. However, these educational centers would have to thoroughly upgrade and update faculty, incorporating private sector concepts and practices and modern insurance standards into their educational programs.

ANNEX FIVE

INSURANCE GUIDELINES OF THE ORGANIZATION FOR ECONOMIC AND DEVELOPMENT (OECD)

Rule No. 1. Adequate prudential and regulatory provisions should be enforced in order to ensure the soundness of the insurance markets, the protection of the consumers and the stability of the economy as a whole. Over-regulation should be avoided. The insurance regulatory framework must be adapted to the characteristics of individual countries and encourage the stability, while maintaining the necessary flexibility to meet developments in the market.

Rule No. 2. Sufficiently strict licensing criteria should govern the establishment of insurance companies. Among these criteria, testing of the nature and adequacy of the financial resources of insurance companies, in particular through analysis of business plan and the requirement for a minimum level of capital (taking account of inflation) deserves particular consideration. Other key requirements are related to the assessment of the ability of the company to meet legal, accounting and technical requirements and last but not least requirement for a competent management (fit and proper provisions).

Rule 3. The Underwriting of insurance risks should be restricted to the insurance companies, which may transact insurance (and related) operations only. Life and non-life activities should be separated (in distinct companies), so that one activity cannot be required to support the other. The distribution of insurance products by entities from other sectors may be authorized. Tasks associated with the activities and the structure of financial conglomerates should be adequately monitored.

Rule No. 4. Establishment of foreign insurance companies should be based on prudential but non-discriminatory rules. Liberalization of cross-boarder operations, at least concerning reinsurance and international risks, should be encouraged.

Rule No. 5. Adequate insurance contract laws should be established. Rules governing contractual rights and obligations as well as related sanctions, are essential for the protection of both contractual and third parties and indispensable for the development of legal stability. In the absence of contract laws, the approval of policy conditions by the supervisory authority may prove all the more necessary.

Rule No. 6. Due to crucial economic and social role of insurance in the development of an economy, consideration should be given to tax issues in the life insurance and pensions field in transaction economies.

Rule No. 7. The establishment of a supervisory body is essential. The supervisors should be professionally independent and properly trained and impartial. The supervisory body should have sufficient personnel and financial resources as well as adequate powers (including sanctions) to carry out its tasks.

Rule No. 8. The examination of records and on site inspections of insurance companies is at the core of the work of the supervisor. An adequate reporting system is essential to achieve this task

properly. The secrecy of information communication to and between supervisors should be safeguarded.

Rule no. 9. Monitoring solvency and capital rations constitute a key element of dynamic supervision. But adequate tariffication and prudent provisions backed by reliable and equivalent assets remain the fundamental requirements for maintaining solvency. Adequate business management and reinsurance activities are also indispensable to safeguard the soundness of the companies.

Rule No. 10. Initially at least, it may be advisable for economies in transition to request the submission of premium rates and insurance products for prior approval. Supervision of tariffs and products should however be adapted to the particular situation of each country and reassessed at a later stage according to the development and progress of the market.

Rule No. 11. Supervisory authorities should take adequate, effective and prompt measures to prevent insurance companies from defaulting, and to arrange an orderly run-off or the transfer of portfolio to a sound company. Appropriate winding up procedures should be enforced. Under certain conditions, and particularly if the national market comprises a sufficient number of potential contributors with broad spread of risks, the creation of a compensation fund could be considered.

Rule No. 12. Standardized accounting rules are essential to ensure the transparency and comparability of financial situation of insurance companies. Adequate insurance accounting rules and requirements for reporting and disclosure have to be set as a priority action. The compilation of statistical data regarding the frequency and severity of losses is an essential condition for computing tariffs and technical provisions accurately. Tariffs should be based on statistical data. Actuarial techniques are key components of insurance management; role of the actuarial profession could be encouraged.

Rule no. 13. Investment regulation should ensure that both security and profitability requirements are respected. It should promote the diversification, spread and liquidity of investments portfolios as well as the maturity and currency matching of assets of assets and liabilities, although some temporary dispensations to the last principle may be necessary. In any case, account should be taken of the country's current economic environment. Regulations might include a list of admitted assets on which ceilings may be set and requirements on the way in which investments should be valued.

Rule No. 14. Regulation should not restrict free access to international reinsurance markets. Compulsory sessions of risks to domestic/national reinsurers should therefore be avoided. The collection and monitoring of information relating to reinsurance companies should be established. International co-operation is particularly important to obtain information and should be strengthened.

Rule No. 15. Insurance intermediaries should be registered in order to ensure their compliance with selected criteria. Insurance intermediaries should possess appropriate qualifications and provide adequate information to policyholders including disclosure of limits to their

independence such as significant ties with insurance companies. Insurance brokers should possess either financial guarantees or professional liability insurance.

Rule No. 16. Compulsory insurance may be justified in respect of certain forms of social protection and might be considered in other areas where the risks covered are particularly serious, or where premium payments should be divided on an equitable basis among policyholders group under consideration. Compulsory insurance is particularly recommended for automobile third party liability. Guarantee funds could be created to compensate victims when there is no insurance cover. Tariffs for compulsory insurance should be based on statistical data. Adequate monitoring systems should be established. Compulsory insurance should not be restricted to former monopolies or state owned companies.

Rule No. 17. Regulations should allow for fair competitions within the insurance and reinsurance market. The process of dismantling monopolies and the privatization of government owned insurance companies should be strongly encouraged.

Rule No. 18. The activities of insurance companies in the pensions and health insurance fields should be encouraged within an appropriate regulatory and supervisory framework. Regulations should endeavor to ensure fair treatment between all private companies operating in all areas.

Rule No. 19. Governments should strengthen cooperation in order to exchange information on insurance regulation and supervision, facilitate the monitoring of the activities of foreign insurance and reinsurance companies and promote the development of sound, modern and open insurance markets.

Rule No. 25. The insurance industry should be encouraged to set up its own business guidelines and to develop adequate training structures. Self regulatory principles and organizations, including professional bodies, can complement usefully the public supervisory structure.

Note: The above guidelines are included in the December 14, 1960 Paris convention of the Organization for Economic Cooperation and Development and came into force on September 30, 1961 for the original member countries. Article 1 of the Convention states that OECD shall promote policies designed:

- To achieve the highest sustainable economic growth and employment and a rising standard of living in Member countries, while maintaining financial stability, and thus contribute to the development of the world economy.
- To contribute to sound economic expansion in Member as well as non-member countries in the process of economic development, and
- To contribute to the expansion of the world trade on multilateral, non discriminatory basis in accordance with international obligations.