REGULATION OF INSURANCE INDUSTRY IN INDIA

Dissertation submitted to Jawaharlal Nehru University in partial fulfilment of the requirements for the award of the Degree of

MASTER OF PHILOSOPHY

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DECLARATION

This dissertation entitled **"Regulation of Insurance Industry in India"** being submitted to the Centre for Economic Studies and Planning, School of Social Sciences, Jawaharlal Nehru University, New Delhi, in partial fulfilment of the requirements for the award of the degree of MASTER OF PHILOSOPHY, is my original work and it has not been submitted in part or full for any other degree of this or any other University.

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We recommend that the dissertation be forwarded to the examiners for evaluation.

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INTRODUCTION

The insurance industry in India was opened to domestic and foreign private companies in 1999, ending the monopoly of the Life Insurance Corporation of India (LIC) over the business of life insurance since 1956 and that of the General Insurance Corporation of India (GIC), or its four subsidiaries, over the non-life sector since 1972. The liberalisation of the insurance sector was accompanied by the setting up of the Insurance Regulatory and Development Authority (IRDA) as a statutory body to regulate the insurance industry. As the name itself suggests, the IRDA has been envisaged as the authority responsible not only for protection of interest of the insurance buying public through prudential regulation of the companies and supervision of their market conduct, but also to 'promote and ensure orderly growth' of the insurance industry, a feature not common to the insurance regulatory authorities in different parts of the world. The duties, functions and powers of IRDA have been determined by the Insurance Regulatory and Development Authority (IRDA) Act, 1999, which included amendments to the Insurance Act 1938, the Life Insurance Corporation Act 1956 and the General Insurance Business (Nationalisation) Act 1972. During the four years of its existence (since 19th April 2000), the IRDA has also laid down a series of regulations concerning the different aspects of the business of insurance in India, within a framework provided by the IRDA Act, 1999 and the Insurance Act, 1938. The powers and functions of IRDA together with its regulations constitute the regulatory regime for insurance industry in India.

This study tries to assess the current regulatory regime in India keeping in mind the primary objective of regulation of insurance; the different types of regulatory interventions for which there exists a case in theory; the range of insurance regulatory practices that are followed in different countries; and the specific problems that could arise in the voluntary market for private insurance in India. The study tries to capture the theoretical underpinnings of the different objectives and techniques of regulating an insurance industry as also to draw lessons from the experience of a number of countries with insurance and its regulation in order to enable an informed evaluation

of the regime of regulation that has been put in place (in India) through the IRDA. The intent of the regulatory authority and its ability to intervene effectively are taken as important parameters for assessment.

The first chapter discusses some important characteristics (or peculiarities) of the system of insurance, the significance of insurance for an individual as well as the whole economy, and some of the relevant issues concerning government intervention in the insurance market. Apart from summarising the different lines of argument relating to government intervention in a competitive insurance market, this chapter develops an important insight about the fallacy of the argument (put forward by many economists) that a liberalised, competitive insurance industry will generally lead to a better environment for the consumers in which they are charged lower premiums than before, given better risk coverage, and provided better services by the insurance companies.

The second chapter briefly discusses the main rationale for regulation of insurance as well as the various objectives that are/can be assigned to it, and develops an understanding about the underlying theory as well as the practice followed with respect to the different types of regulatory measures which can be used in the insurance industry. The various kinds of regulatory measures are discussed under three broad areas of regulation, viz., structural regulation, solvency regulation and market regulation. Then, the third chapter presents a survey of insurance regulation in the United States and the European Union (the two largest competitive markets for insurance in the world), Japan and China (both following relatively strict regimes of regulation), and Poland (a country whose experiences with liberalisation of insurance sector and adoption of a relatively liberal regulatory regime throw up important lessons). The fourth chapter provides an overview of the developments in Indian insurance sector starting from the nationalisation of life insurance and non-life insurance to liberalisation of the sector towards the end of the 1990s and the setting up of IRDA. The fifth chapter captures the main contours of the insurance regulatory regime in India- the legislative framework for insurance regulation, powers and functions of IRDA, relevance of the Tariff Advisory Committee (TAC) and the recent developments relating to deregulation of rates, the Institution of Insurance

Ombudsman, and regulations laid down by the IRDA. And, this chapter presents an assessment of the legislative framework and the regulations laid down by IRDA, with the theoretical insights and practical lessons on the different regulatory issues as the backdrop. The study ends with concluding remarks on some of the important issues discussed.

Chapter I

INSURANCE INDUSTRY: CHARACTERISTICS, SIGNIFICANCE, AND NEED FOR GOVERNMENT INTERVENTION

The most fundamental character of the business of insurance is represented by the contract between the insurer (i.e., the firm which sells a promise of indemnification) and the insured (also called, insuree, who is the individual or firm that buys this promise). The essence of this contract is the payment of a fee by the insured in exchange for the insurer's promise to pay a certain sum of money provided a stipulated event occurs. In order to see how the insured benefits from buying such a promise, we must consider two main features of the insurance mechanism. The first is the fact that pooling of risks and its redistribution among a large enough group of people is one of the basic functions of an insurance mechanism. Secondly, such a mechanism works through a systematic way of organising experience to provide coverage against future contingencies.

This chapter first discusses some of the important characteristics, or peculiarities, of the system of insurance. Then it deals with the question of significance of insurance for an individual as well as for the whole economy. The chapter ends with a detailed discussion of the need for government intervention in the insurance industry.

IMPORTANT FEATURES OF THE SYSTEM OF INSURANCE

Logic behind Pooling of Risks under Insurance

The contingencies that may affect an individual's life are guarded against by aggregating a group of individuals together under the insurance system. Simon (1987) explains the logic behind pooling of risks through the following arguments. An individual might wish to save some of his present earnings for meeting the possible contingencies in future, for which he takes resort to, say, a savings account (instead of

an insurance coverage). The present income, and whatever surplus over immediate needs it provides, would place a constraint on the amount this individual could devote to savings. Even if we assume a high enough income and return on invested savings for the individual, the ability to provide for all contingencies, which could range from job loss, illness for a prolonged period, or permanent disability to damage of valuable property by fire, etc., is implausible for the average person. Secondly, it would be quite advantageous to know in advance when the various contingencies would be realised, if at all. Knowing the amount of time the individual would have to save before the particular contingency comes up would make it far more possible to choose an investment strategy to meet that contingency. While such a certainty is impossible for the individual, it can be approached if we take into account a large group of people.

Pooling of risks under an insurance system leads to a sharing of risk among all the insured, and then to a distribution of losses among them, if and when such losses arise due to contingencies which have been insured against. For example, past experience may suggest that, out of a given population of buildings which have been insured with a particular insurer, 4 % will be affected by fire in a given year. Dividing the total anticipated claims by the total numbers seeking insurance would give us the premium to be paid. At the end of a year, suppose we find that the insurer indemnified the losses caused by fire for a certain number of insured houses. Then those who haven't had a fire have contributed to a pool to pay for those who have, while buying protection in case they were the unfortunate ones.

Another important feature of the insurance mechanism is that it leads to a reduction in the aggregate level of a risk for which insurance coverage is sold.

Reduction of Aggregate Risk

The insurance mechanism involves a reduction of risk (and the uncertainty related to risk) for the whole group of people who have insured against an identical risk. The risk which an insurance company faces is not simply a sum total of the risks transferred to it by individual insurees, for the company can predict with reasonable degrees of accuracy the amount of losses that will actually occur over a certain period

of time. By combining a sufficiently large number of homogeneous risk exposure units, the insurer is able to make predictions for the group as a whole. As far as its predictions are completely accurate, the insurance company faces no possibility of loss, for it will collect each individual insuree's share in the total losses as well as in expenses of operation, and use these funds to pay the losses and expenses as they occur. If the predictions are not accurate, the premiums which the insurer has charged might be inadequate. The accuracy of the insurer's predictions is based on the Law of Large Numbers.

Implications of the Law of Large Numbers for Insurance

Simply put, the law of large numbers states that- the observed frequency of an event more nearly approaches the underlying probability of the population (i.e., the underlying probability of occurrence of the event with respect to the selected population) as the number of trials (observed) approaches infinity.

This implies that when the insurance companies do not know the underlying probability of an event, and they cannot deduce it from the nature of the event, they can estimate it on the basis of past experience. However, the estimated value of probability of occurrence of an event is more accurate if the insurance company uses a sufficiently large sample for observing past occurrences of the event. The specific implications of the law of large numbers for the operation of insurance companies are as given below.

(1) In order to estimate the underlying probability of an event accurately, the insurance company must have a sufficiently large sample. The larger the sample, the more accurate will be the estimate of the probability.

(2) Once the probability of an event has been estimated, it must be applied in practice to a sufficiently large number of exposure units which would permit the underlying probability of the event to work itself out.

Thus, for the insurance company, the larger the number of cases examined in the sampling process, the better the chance of making a good estimate of the probability

of occurrence of a contingency. Also, the larger the number of exposure units to which the estimate is applied, the better the chance that actual experience will approximate a good estimate of the probability (Elliott and Vaughan, 1972). As far as the actual occurrence of contingencies differs from the predictions made, risk exists for the insurer. Reduction of this risk for the insurer depends directly on the extent to which accuracy in predictions is attained.

Insurance Market in Neo-classical Economics

Arrow (1970) observed that, unlike goods and services, transactions involving insurance are an exchange of money for money, not money for something which directly meets needs; and the distinct character of an insurance contract is that it is an exchange of money now for money payable later contingent on the occurrence of certain events. Individuals are considered to be incapable of predicting the time and magnitude of events that profoundly affect their well-being, as a result of which they are affected by uncertainty about their future. Insurance is seen as the most prominent institution for diluting the pernicious influence of this uncertainty. Thus, the individual wants to invest in a host of activities at the present to ensure that the timing and magnitude of unfortunate future events will be less harmful (McCall, 1994). This is how a demand for insurance contracts exists in the economy. Now, the question is whether a supply of insurance will be forthcoming at a price that would be acceptable to the people who have a demand for insurance, which will lead to an active insurance market. Though it is possible that trade occurs as a result of differences in risk preferences of the various parties involved in a contract or because of differences in assessments of the various parties regarding the probability of occurrence of an event, these reasons are not adequate and there exist more likely reasons for expecting active insurance markets.

It is understood that the marginal cost of risk normally increases with an increase in the amount of risk borne. Therefore, the cost of one additional unit of risk will be higher for a person who has a greater amount of risk in total than someone with a lower aggregate risk. Hence, an agent facing a high personal risk will be willing to pay more (i.e., a greater amount) to offload a certain part of the risk than someone with a less exposed position will require as a payment to take the risk on. This is how

'risk spreading' acts as a motive for trade in insurance contracts (De Meza, 1994). Arrow and Lind (1970) (as referred to in De Meza, 1994) formalised this motive, showing that the cost of risk tends to zero as the number of people sharing a risky project tends to infinity. Another motive for trade in insurance contracts is 'risk pooling'. If we consider the risk exposures of a large number of people in an economy (with respect to a particular type of contingency), then all those risks are not perfectly positively correlated, i.e., there exist different risk types in the group. And, an insurance company selling coverage to a large number of people can predict the level of future claims from the group as a whole with an error that can be restricted to very low levels (with the help of the Law of Large Numbers). Once the company has a fair amount of idea about the total amount of losses to be compensated in future, it can sell insurance coverage to risk-averse individuals at an average price.

However, as has been well recognized in neo-classical economics since late 1960s and 1970s, an insurance market does not function so smoothly in reality. Rather, it can fail (i.e., the market may not provide a Pareto Optimal outcome, which is such an outcome that it leaves no scope for making one person better off without making another person worse off) because of the problems created by asymmetric information. Neo-classical economists started giving importance to the role played by information, or rather the asymmetry of information among the different agents involved in a trade, in influencing the outcomes in a market, in the 1970s. Under the conventional notion of a market, with buyers and sellers coming together to trade; in a full information equilibrium- there is a single price, markets clear and all individuals and firms view themselves as price takers, the price charged is independent of the quantity purchased, and also conventional economic theory has shown that under fairly weak conditions such a competitive equilibrium exists and is Pareto Optimal. All of these statements become questionable once the imperfections of information (available to the different agents in such a competitive economy) is taken into account. Under an environment of imperfect information, there may not be a single price in equilibrium, firms do not act as price takers, prices do more than just clear markets-they convey information, prices charged may depend on the quantity purchased, and competitive equilibrium may not exist and may not be Pareto Optimal (Stiglitz, 1977). Two basic problems of imperfect information which come up in an insurance market are 'moral hazard' and 'adverse selection'.

Moral Hazard

Moral hazard in the insurance market refers to the problem that the insurance policy itself might change the incentives of the insured to take care to prevent loss (against which insurance coverage has been taken) and thereby it can change the probabilities upon which the insurance company has relied (Arrow, 1970). By paying a premium to the insurance company for the coverage against a particular loss, the insured transfers the risk associated with that loss to the insurance company. However, this risk transfer can affect the incentives and hence the behaviour of the insured with respect to prevention of that loss. When the untoward event occurs, the insurance company is not sure whether it occurred by chance or it was caused by the carelessness of the insured. If the insurance policy compensates the insured fully, or by an amount that is more than the amount of loss, then there exist no incentives for the insured to take care to prevent that loss. This possibility of the insurance policy altering the incentives of the insured is what is commonly referred to as the problem of moral hazard.

The roots of this problem lie in the inability of the insurance company to observe the actions of the insured costlessly. If the amount of care taken is observable without any significant cost, then the insurance company can base its rates on the amount of care taken. In real life, insurance companies usually charge relatively lower rates to businesses which have better fire prevention systems in their building, and they charge smokers different rates than non-smokers for health insurance. In these cases, the insurance company tries to discriminate among the customers depending on the choices they have made that influence the probability of damage, when it is possible for the companies to observe the relevant actions of their customers without a significant cost. In all other cases, the moral hazard problem will exist for the companies, i.e., full insurance could mean that too little care will be taken as the insured doesn't bear the costs of his actions. The partial solutions put forward for this problem are that moral hazard can be reduced by requiring the insured to bear some of the costs of the contingency (i.e., by not compensating for a loss fully) and/or by monitoring the insured's behaviour with respect to prevention of the contingency (McCall, 1994).

Adverse Selection

The problem of adverse selection arises when potential policyholders know their own characteristics (or risk types) better than do the insurance companies. The maximum amount that any policyholder will agree to pay as the premium would be in accordance with the amount of claims which he expects to make on the company in future. Thus, the policyholders of the bad risk type (i.e., those with a relatively higher risk exposure than others in the group) will be ready to pay a higher premium than those who belong to the good risk type. The insurance company, unable to distinguish between the good and bad risk types before the occurrence of contingencies, will settle for a rate that will be somewhere in between of what the two sets of policy holders are willing to pay. But since the premium rates are set at a level higher than what the good risk types see as justifiable for them, the good risk types will drop out of the market, and the insurance company will be left with the bad risk types only giving them coverage at a rate less than what they should pay because of their higher risk exposure. This kind of a situation is known as an adverse selection for the insurance company.

Insurance companies can and they do cope with this problem by: (1) experience rating, i.e., continually adjusting premiums to reflect the size and incidence of each insured's claims and (2) designing policies that elicit the information necessary for partitioning agents into distinct categories (ibid).

An important question in the context of these information-related problems is whether some sort of government intervention could improve the outcomes in the insurance market even if the government had the same information problems as the insurance companies. This question will be discussed in the last section of this chapter.

SIGNIFICANCE OF INSURANCE FOR AN INDIVIDUAL AND FOR THE ECONOMY

The needs for a system of insurance arise mainly because of two fundamental reasons. The first is that individuals, firms and the society as a whole face different kinds of risks, which, if realised, can cause significant losses. And, both individuals as well as firms are incapable of managing many of those risks as competently as the system of insurance can. The second fundamental reason therefore can be traced in the primary functions performed by insurance, which are: (1) it transfers risks from an individual or a firm to an entity which is better able to cope with it and (2) it leads to a sharing of losses, on some equitable basis, by a large number of people.

Why Does an Individual Need Insurance

From an individual's point of view, insurance can be defined as an economic device whereby he (the individual) substitutes a small certain cost (the premium) for a large uncertain financial loss (the contingency insured against) which can occur in the absence of the insurance contract (Elliott and Vaughan, 1972).

(1). What insurance mainly provides to the insured is a form of security from financial loss which could arise from a certain contingency. Insurance does not decrease the uncertainty for the individual as to whether or not the event will occur, nor does it alter the probability of occurrence, but it does reduce the probability of financial loss associated with the occurrence of the event. Thus, for an individual, insurance, by reducing the probability of financial loss, also reduces the uncertainty regarding the economic burden of losses.

(2). The insurance device works as a method of loss distribution among a group of people who are insured for a contingency. What would be a devastating loss to an individual is spread in an equitable manner to all members of the group of insured.

(3). An individual may take life insurance for ensuring a certain amount of financial assistance to his dependants after his death, or annuities for meeting his financial needs when he is unable to earn adequately.

Significance of Insurance for the Economy

From the point of view of the society as a whole, insurance works as an economic device for reducing and eliminating risk through the process of combining a sufficiently large number of homogeneous exposures into a group in order to make the loss predictable for the group as a whole (ibid). The system of insurance makes a number of important contributions to economic activities carried out by different agents, and it is also seen as an institution that promotes economic growth.

(1). Insurance promotes financial stability among individuals and firms (Carmichael and Pomerleano, 2002). In the absence of any insurance coverage, individuals would face a greater chance of suffering substantial financial losses in the wake of different contingencies. Also, without insurance, the rate of failure of business enterprises would be higher, with consequent losses for other businesses, employees and tax revenues of the state. The financial stability provided by insurance helps individuals and firms undertake their economic activities without the burden of making preparations for absorbing financial losses that could arise because of certain untoward events.

(2). Insurance promotes entrepreneurial activities in the economy. An entrepreneur might have to experience unforeseen events causing severe financial losses to his business venture. In the absence of insurance coverage for such losses, people would hesitate to put their money into a new venture. By providing coverage against certain kinds of losses that could afflict a new business venture, insurance helps in the process of expansion of economic activities. Besley (1995) notes that insurance may play an important role in relation to the incentives that exist for adopting new, riskier technologies.

(3). Insurance compliments economic growth through its impact on trade and commerce. Many goods are transported long distances between the buyer and the seller, and insurance to cover the potential damage during transit facilitates such exchanges (Carmichael and Pomerleano, 2002.).

(4). Insurance provides for a more efficient utilization of finance capital (Elliott and Vaughan, 1972). But for any insurance mechanism, individuals and businesses would be obligated to maintain relatively large reserve funds to meet the risks or contingencies in future. The funds would either be in the form of idle cash, or invested in safe, liquid, but low- interest- bearing securities. This would be an inefficient use of finance capital. Besley (1995) observes that for any given aggregate level of savings, the quality of financial intermediation is a crucial determinant of the efficiency of investment choices, i.e. in ensuring that savings find their way into the most productive opportunities. Through an insurance company the risks are pooled among a large group and there is reduction of aggregate risk by reasonably precise prediction of contingencies. Insurers, as a result, are required to maintain much smaller reserves, on an aggregate level, and the funds collected (through premiums) are also available for investment in more productive avenues, the returns on which can be expected to be much higher.

(5) Life insurance companies are usually in an advantageous position than property and liability insurance companies, when it comes to making investments of a long term nature. An important feature of life insurance, especially in developing economies, is the bundling together of risk coverage and savings (Ranade and Ahuja, 1999). In life insurance, when there is a bundling of risk coverage and savings and the contract period is over a long time, a part of the premium paid by the insured goes towards buying coverage while the other part towards savings. While a bank depositor can reclaim savings anytime on 'demand', in case of life insurance the insured cannot reclaim the savings component without a penalty; because such reclaim of the savings embodied in premium payments amounts to canceling or renegotiating the insurance contract, and hence the penalty (ibid.). Both the savings component of the premiums as well as the long term nature of the contract enable life insurance to play an important role in channelising funds towards investment projects with long gestation and long payback periods. Typical examples of such projects are infrastructure projects, which have high capital costs, low operating costs, substantial risks and sunk costs and high debt to equity ratio in their financing (ibid.). In the context of developing countries, substantial infrastructure investment is considered necessary for accelerating economic growth.

(6). Insurers facilitate economies of scale in investment. Many investment projects in emerging markets, which are large in relation to the available financial capital, often enjoy economies of scale and promote specialization and technological innovations. The insurance industry can often meet the financing needs of such large projects, thereby helping the process of economic growth (Skipper and Klein, 1999).

(7). Insurers gather substantial information to conduct their evaluation of firms, projects, and managers both in deciding whether and at what price to issue insurance and also to make investment of their funds. While individual savers and borrowers may not have the time, resources, or ability to undertake this information gathering and processing, insurers have an advantage in this regard and are better at allocating finance capital (ibid.). Insurers will choose to insure and provide funds to the most sound and efficient firms, projects, and managers.

GOVERNMENT INTERVENTION IN THE INSURANCE MARKET

Conventional economic theory clearly distinguishes social insurance from private insurance, identifying the former within the domain of welfare activities undertaken by the state and the latter as falling under the domain of 'market'. This kind of division seems to be driven by the philosophy that those individuals in an economy, who have the ability to participate in a private market for insurance, should indeed do so; as the market, in particular, a competitive market, can lead to an efficient (i.e., Pareto Optimal or Pareto Efficient) equilibrium outcome. All individuals participating in such a market maximize their expected utilities while the firms are able to break-even. However, the state, through its social insurance programmes, should cater to those sections of the society who are left out of the private relationships shaped up in the market. And, the scope for government intervention in the functioning of a market arises only when the market fails to provide an efficient outcome.

While an insurance market can fail to provide a Pareto efficient outcome due to a number of reasons, the most prominent are the reasons related to incomplete or asymmetric information. As a result, in the field of economics of insurance, a lot of attention has been given to market failures due to asymmetric information and the consequent role for government intervention to rectify such failures, if possible.

However, an alternative approach to study the insurance industry has also been adopted by some economists who have tried to capture the effects of neo-liberalism on insurance practices and made a number of critical observations on the functioning of private insurance industry on the basis of empirical research.

This section presents some of the important issues related to the rationale for government intervention in the insurance market.

Ability of the Government to Provide Insurance Services

In the context of shifting of risks through the system of insurance, Arrow (1970) observes that the explanation for the existence of insurance companies is that: it is profitable for all concerned that risks be shifted to 'the agency best able to bear them through its wealth and its ability to pool risks'. However, he also adds that 'the government, above all other economic agencies, fits this description'. Thus, the government also can provide insurance services. In fact, insurance companies find many risks as 'uninsurable' (though it is only a relative concept varying from company to company). Whether a particular risk is insurable for a company would depend on its ability to bear that risk, which, in turn, depends to a large extent on its wealth and ability to pool risks. On both of these criteria, the government would seem as the institution with the least number of uninsurable risks in an economy. In reality, apart form the social insurance programmes, the governments in many countries also provide certain forms of private insurance, such as, crop insurance (which compensates a farmer according to how much the yield on a particular crop or a set of crops falls below some specified level), health insurance (which typically pays a sum of money indexed to an individual's consumption of medical care), etc.

However, it has become a common practice among the mainstream economists to argue for a competitive insurance industry, characterised by the presence of a sizable number of private insurance companies. Many developing countries in the recent past, for instance, China and India, have subscribed to such views and undertook 'opening up' of their insurance industries to domestic as well as foreign private companies. It is worthwhile to consider some of the central arguments put forward by people who

advocate significant presence of private companies in the insurance market of a country.

Arguments in favour of a Competitive Insurance Industry Led by Private Firms

(1) Neo-classical economics postulates that perfect competition in a market would lead to an efficient outcome and, in the context of an industry like insurance which plays a significant role in channeling savings towards different sectors of the economy; it would lead to an optimal allocation of resources. However, this kind of a competitive environment and its optimal results cannot be expected in an industry in which only public sector insurance companies are competing with each other; as such companies will lack complete autonomy to take decisions regarding their business strategies, there will be a high chance of collusion among these companies, they could be obstructed by certain social objectives (which of course is one of the primary reasons for establishing public sector firms) like channeling their investible premium funds towards financing government projects and thereby the flow of funds to the private corporate sector will be restricted, there will be a very low level of product experimentation and innovation due to the absence of any appropriate incentives or pressures, and so on.

(2) However, those who advocate a competitive insurance market do admit that 'perfect competition' is an ideal that cannot be realized, and therefore they argue for an insurance market to be 'workably competitive'. A workably competitive insurance market is considered to function well and provide most of the benefits of competition. Markets characterized by 'workable competition' generally have low entry and exit barriers, numerous buyers and sellers, good information, governmental transparency, and the absence of artificial restrictions on competition (Skipper and Klein, 1999). Such a workably competitive insurance market is expected to result in a greater choice of products and lower premium rates for consumers, a continuous process of product innovation, and a more efficient allocation of scarce investible resources in the economy.

(3) While price competition can lead to lower premium rates for the customers, quality competition among the insurance companies can indeed lead to better

coverage of risks being offered under various insurance policies (without an accompanying increase in premium rates to the same extent), and finally, competition in service provided by the companies can potentially lead to the customers being properly advised by insurance agents and to a prompt and fair settlement of claims (Elliott and Vaughan, 1972).

(4) A competitive insurance industry, marked by the presence of a sizable number of firms, can facilitate the process of reinsurance significantly. The number of insurers participating in a reinsurance agreement has no upper limit and insurance companies can choose to reinsure substantial portions of their original business. Therefore, an active reinsurance market helps in enabling the underwriting of large risks, stabilizing underwriting results of companies, spreading risks among a larger group of entities, and reducing the chances of insolvency of insurance companies.

(5) When many insurance companies are operating, different companies can be encouraged (if needed through state intervention) to specialize in specific lines of insurance. Specialization of a company in a particular line of insurance would enable that company to predict the aggregate level of losses occurring because of a certain contingency with better precision. This would result in a further reduction in aggregate risk facing the society.

However, in practice, competitive insurance markets, marked by the presence of a sizable number of private firms, lead to welfare losses on several grounds. This is evident from the extensive regulation of insurance industry which has been adopted by many countries, most notably, the United States. Even if we keep aside the empirical evidence about the failure of firms, there exist several theoretical arguments that necessitate government intervention in the insurance market.

Government Intervention Necessitated by Market Failure (Other than Moral Hazard and Adverse Selection)

(1) An insurance company indulges in price competition by charging lower premium rates than others for policies providing identical levels of coverage against a certain kind of risk. For a given level of coverage against a particular type of risk, the prices

charged by a company can be brought down only if it can cut down its costs. The costs, in turn, get determined mainly by: cost to the company on account of indemnification of losses (to its customers), expenses on account of sales operations, administrative expenses, and taxes. Given the same coverage of risks in its policies as before, the same aggregate level of risk exposure (of the company), same expenses on sales and administration, and no change in taxes, it will not be feasible for the company to cut down its premium rates below a break-even level. However, under the pressure of fierce competition in the market, such a company might lower its premium rates to uneconomic levels, which can result in failure of the company after a time. Similarly, if a company offers too much of risk coverage to its customers for the same level of premiums, it will be detrimental to the financial health of the company. Thus, a 'cut throat competition' in the market can cause insolvencies of insurance companies. However, such insolvencies ultimately result in substantial financial losses (in terms of the premium paid) for people who have relied on those companies. Due to this reason, even the supporters of a liberal competitive market for insurance (for instance, Ranade and Ahuja, 2000) argue for regulation of the insurance industry to ensure a 'fair competition' and not let it become 'cut-throat competition'.

(2) Another consequence of the insurance companies trying hard to cut down their premium rates is a continuous process of unpooling of risks in the society. The costs to a company on account of indemnification of losses to its clients is the biggest factor that determines its overall financial position. In order to cut down costs, every insurance company can (in fact, it does) target this indemnification part, for which it will try to exclude all those insurees who have a higher risk exposure and hence a higher probability of making claims and will prefer only those who have low risk exposure. Mainstream economics of insurance completely ignores the consequences of this kind of risk unpooling by firms, because the firms are expected to behave as rational agents trying to maximize their profits or minimize the losses. However, some of the main consequences of such behaviour of companies must be noted here.

(a) To the extent that one company (or a group of companies) succeeds in restricting its client base only to a select group of individuals with lesser risk exposure than the average (for a society as a whole), the rest of the companies (in the same line of insurance) will have to manage the individuals with higher risk exposures, with

higher probabilities of losses and/or higher magnitudes of losses (Elliott and Vaughan, 1972). In that eventuality, the latter group of companies will try to charge higher premium rates from their 'substandard' customers; however, the forces of competition might again not allow these companies to do so. Thus, the companies operating on unfavourable terms will eventually become insolvent and exit the market, and, the consequences for their insurees will be substantial financial losses.

(b) This kind of risk unpooling/fragmentation behaviour of the insurance companies cannot get restricted to one company alone; rather it becomes a systemic feature. As a result, the insurance market defies one of the fundamental objectives of the institution of insurance, which is pooling of risks among a large number of risk exposure units in order to facilitate sharing of losses by all in a group.

(c) Finally, this reveals the fallacy of the argument made in favour of a liberal competitive insurance industry that such an environment will generally lead to lower premium rates, better risk coverage and better claims service. Premiums can come down, coverage may expand and claims service can improve, but only for a select group of people facing lesser exposure to risks, not for the entire group of people taking part in the insurance market. As Gowri (1997) (as referred to in Ericson et al., 2000) observes, one of the ironies of insurance is that, while it is supposed to pool risks, in practice it tends to unpool them, breaking down the larger pool of potential insured in search of smaller, less risky pools, which are more advantageous for some, while excluding others. Premiums within these smaller pools can be kept lower and claims service can be higher, but only for those fortunate enough to be included (Ericson et al., 2000).

This risk fragmentation tendency of the insurance market makes government intervention in some form essential to check the exclusion of people, more vulnerable to losses, from the institution of insurance.

(3) Another factor that necessitates government intervention in the insurance market is 'market misconduct' by the firms. The behaviour of insurance companies can result in significant losses for their policyholders by indulging in unfair or fraudulent practices, and by not disclosing adequate information about their financial position.

Government Intervention to Address the Problems of Moral Hazard and Adverse Selection

In recent years, a dominant view in mainstream economics as regards government intervention in financial markets has been that the government should justify all attempts to intervene in financial markets with a clear reference to a market failure that is being confronted. Under this 'market failure' view, one needs to justify that the intervention will genuinely provide an improvement over the initial state of affairs (Besley, 1995).

In the insurance market, moral hazard refers to the tendency of insurance protection to alter an individual's motive to prevent loss, which affects expenses for the insurer and therefore, ultimately, the cost of coverage for individuals (Shavell, 1979). As regards reducing moral hazard with the help of the market itself, standard prescription of economists have been two partial solutions to this problem.

First, is incomplete coverage against loss, for incomplete coverage, by exposing an individual to some financial risk, gives him a motive to prevent loss. In practice also, a 'deductible' in the form that the insured must bear a certain proportion of the total damage caused by a contingency is common. However, this does not solve the problem of moral hazard completely. For, the incentive to prevent loss which is expected to be developed by giving incomplete coverage to the insured depends on the cost of taking care (to prevent loss) for the insured. Different values of the cost of taking care will have different implications for the degree to which coverage should be incomplete. For example, if the cost of taking care is very high, offering full coverage turns out to be optimal for the insurer (ibid.). The second partial solution is that the insurer can 'observe' the care taken by the insured to prevent the loss. If observation of care (either ex ante, i.e., whenever a policy is purchased or ex post, i.e., only when a claim is presented) allows the insurer to link either the insurance premium or the amount of coverage paid in the wake of a claim with the perceived level of care, then it can develop a motive for the insured to prevent loss. However, such observation of care may not always be possible or it may be too expensive for the insurer to be worthwhile. Also, if the insurer's observations are not precise, the

problem arises that using perceived level of care imposes a new kind of risk on the insured; for the premium or level of coverage would depend on the random factors affecting the insurer's observations (ibid.). According to De Meza (1994), offering a no-claims bonus can be a more effective way of containing moral hazard than giving incomplete coverage against losses.

Although giving incomplete coverage against losses is the common practice adopted by insurance companies for tackling moral hazard, mainstream economists do not consider this as any ground for advocating government intervention in the insurance market. In their opinion, if the government faces the same information problems as the insurance companies, if it cannot observe the care taken by the insured, and it can only set prices and quantities in the insurance market; then there is no scope for the government to bring about an improvement in efficiency in the allocation under moral hazard. This kind of a view precludes the possibility that the government can use any other tools at its disposal which the insurance companies do not have. If we relax this condition, then it is not difficult to visualize that the government can indeed intervene in a manner that can result in a more efficient allocation. For example, the government can set up some legal apparatus which could compel a particular level of care on the part of the insured.

It may be worthwhile here to briefly consider the notion of 'constrained Pareto efficiency', a more general notion of efficiency (than Pareto efficiency), which has been considered by neo-classical economists as the benchmark for efficiency of allocations in an incomplete market (markets are complete when each agent is able to exchange every good either directly or indirectly with every other agent).Given all feasibility and other constraints on implementing trades in a market (such as, the inability to collect appropriate information about various agents, the costs of operating some kinds of markets, etc.), an allocation is constrained Pareto efficient if there exists no scope for bringing about a Pareto improvement. Greenwald and Stiglitz (1986), in their analysis of pecuniary externalities (i.e., those externalities in which one individual's or firm's actions affect another only through effects on prices, unlike technological externalities in which the actions of one individual or firm directly affect the utility or profit of another) in economies with incomplete markets and imperfect information indicate that- in situations of imperfect information, the

equilibrium allocations are rarely constrained Pareto efficient, because Pareto improving tax interventions for these markets exist almost always. The implication of their finding for an insurance market under moral hazard turns out to be that there is a case for tax intervention by the government in markets that are related to the insurance market.

Let us consider the case of an individual who has insurance coverage against losses that could result from an accident while he is driving. Whenever this individual drives his motor vehicle, there is a chance of an accident. Over a given time period, the longer the distance he drives the higher is the probability of his meeting with an accident, and therefore higher the probability that the insurance company will have to pay for the damage of his vehicle in accident as well as for third party liability. But since this individual has insurance coverage against such losses, he does not take care to drive a shorter distance (over that period of time) for the sake of reducing the chance of an accident. Now, if the government levies a tax on petrol, it will induce this individual to drive a shorter distance than before, which in turn will reduce the chance of accident. Since the expected losses for the insurer are lower now, it should cut down the premium charged to the individual. Thus, even if we ignore the reduced costs of third party liability, if the tax on petrol is set at a low enough rate and the individual is compensated for the tax through a lower premium rate, there is a gain in efficiency achieved by this tax intervention by the government. Similarly, an insurance company giving coverage against damage of a building in fire faces the trade off that full coverage might mean that the owner of the building will take too little care to prevent a fire. In this case, the government can intervene by subsidizing fire extinguishers. In both the cases mentioned above, it is difficult to think of a practical way an insurance company could induce the insured to take similar level of care to prevent loss. Thus, the policy implication of the findings of Greenwald and Stiglitz (op. cit.) is that, in the context of moral hazard in insurance market, government intervention for taxing those goods which complement the careless behaviour of insured parties or subsidizing those goods which reduce the probability of losses can result in efficiency gains.

Adverse selection in insurance market refers to a problem that arises because the insurer does not have costless access to information possessed by the potential policy

holders about their own characteristics. For example, some buyers of health insurance will have more information about their health status than insurance companies. Since the insurance company cannot discriminate perfectly between healthy and ailing individuals (those who face a high chance of ailment and hence a high probability of undergoing medical treatment), it will give insurance coverage to both types of individuals, but the premium charged will be influenced by the higher volume of claims that the ailing policy holders expect to make on the insurance company. As the premium rates are raised to cover the payouts that are to be made to the ailing policy holders or high risk people, the healthy policy holders or low risk people will drop out of this market.

Though, the principle of adverse selection is potentially present in all lines of insurance, its effect is most visible in the field of health insurance. An insurance company cannot base its rates on the average incidence of health problems in the population. It can base its rates only on the average incidence health problems in the group of its potential policy holders. But the people who want health insurance the most are those who face a high probability of medical treatment, which would mean higher claims on the company, and this raises the premium rates beyond a level which the healthy people, or those who expect to make a relatively lower claim on the insurance company, would like to pay. In such a situation, government intervention can make everyone better off by making it mandatory for everyone to purchase health insurance at a rate based on the average risk in the population. The high risk people will be better off as they can purchase insurance at a rate that is lower than the actual risk they face, and the low risk people are also better off as they have to pay a rate which, although higher than what their actual risk level suggests, is lower than the rate that was offered to them when the low risk people were dropping out and mostly high risk people were purchasing insurance. Akerlof (1970) was the first to articulate clearly that, in the light of the adverse selection problem and its consequences on market allocations, compulsory public insurance might produce an improvement over the market outcome.

Akerlof (op. cit.) observed that in order to tackle the adverse selection problem, the insurance companies try as far as possible to exclude the elderly and ailing people from their business, which means that medical insurance is least available to those

who need it most, and he went further to conclude that 'insurance is not a commodity for sale in the open market'. On this basis he argued in favour of Medicare (a federally funded health insurance scheme in the U.S.). According to him, on a cost-benefit basis Medicare could pay off; for it is quite possible that every individual in the market would be willing to pay the expected cost of his Medicare and buy insurance, but at the same time no insurance company can afford to sell him a policy as, at any price, it will attract too many high risk individuals (and thereby make the average price for the whole group of policy holders high).

However, it has been argued (e.g., Rothschild and Stiglitz, 1976) that a compulsory public provision of insurance (which we considered) results in a more efficient equilibrium than the competitive market when it is assumed that only one type of insurance policy is available, and, if the insurance companies are allowed to offer different types of policies (based on different levels of coverage as well as price) the equilibrium reached earlier under public provision of insurance breaks down.

Though the insurance market has been a widely researched topic in mainstream economics, especially within the sphere of information economics, many of its stylized assumptions are not applicable in the case of markets in a developing country. For a developing country, the market failure view of government intervention may not be dependable, as there may exist a much stronger case for government intervention due to numerous reasons, apart from the reasons related to the pitfalls of a competitive insurance market which we have already discussed.

The Case for Government Intervention in a Developing Country

(1) Government policy as regards insurance industry, in a developing country, needs to take into account the fact that poor people are most likely to be excluded from trade in private insurance markets. There are numerous reasons for this, such as, the poor might not be able to afford the premiums even when the premiums are not exaggerating their risk exposure. The poor in developing countries are less likely to be literate and numerate, which could make it very difficult for them to understand the

intricacies of insurance and, therefore, they can be more vulnerable to losses from unfair insurance contracts.

(2) In case of a country like India, which has the majority of its population living in rural areas, the presence of private insurance companies is more likely to get restricted to urban areas only as they may not find it profitable at all to operate in the rural areas. As a result, in the absence of any government intervention to ensure the presence of insurance companies in rural areas, even those in the rural areas who can purchase insurance will find it difficult to access any insurance coverage. In fact, in developing countries, the reliance on informal mechanisms for credit and insurance is much more than in the developed countries (Besley, 1995).

(3) A large part of the population, in many developing countries, depends on agriculture. When agriculture is mostly monsoon dependent, the risks associated with crop failures are high, which the private insurance companies may find 'uninsurable'. If the government does not step in, there can be no crop insurance scheme for farmers.

(4) The capacity of insurance to mobilize savings is well recognized. However, the efficient allocation of these savings by a competitive insurance industry, as advocated by those supporting a liberal competitive environment for insurance, does not acknowledge the crucial socio-economic objectives of less developed countries. Such countries need to channel substantial amounts funds towards the construction of roads, water supply, electrification, schools and so on. Private insurance companies, rather than investing their premium funds in government securities (which are safe but not very profitable), will focus mainly on more profitable securities in the corporate sector and speculative investment in the financial sector.

(5) There may be a strong ground for government intervention in those developing countries which have allowed entry to foreign insurance companies. The multinational insurance companies, with their large asset base spread across many countries, can indulge in undercutting premium rates in order to force smaller domestic companies to do the same. The smaller companies will not be able to sustain their uneconomic levels of premium for long and will then be forced to exit the

market, which may enable the larger multinational companies to monopolise the market.

Thus, there exist sufficient reasons for government intervention in the insurance market. But that intervention could be in different forms, such as, compulsory public provision of insurance, operating public sector insurance companies in the market for private insurance, or state regulation of the insurance industry. Of all these, state regulation of insurance industry is the most prevalent form of government intervention in many countries at present. There seems to be a consensus among economists regarding the need for state regulation, with even those adhering to the market failure view of government intervention not questioning it. There are of course different views on what should ideally be the scope of such regulation, what should be the objectives of regulation and so on, however, the presence of a regulatory system has been accepted by all as essential.

Chapter II

REGULATION OF INSURANCE INDUSTRY

Economic regulation refers to the government-imposed restrictions on firm decisions over price, quantity, entry and exit, and in some cases also on the decisions over quality of products and investments. As regards the insurance industry, the rationale for state regulation is a derivation mainly of the reasons for government intervention which we have already discussed in the previous chapter. However, the focus of this study being on regulation of insurance, it seems worthwhile here to briefly discuss the rational for insurance regulation as well as various objectives that can be assigned to regulation before moving on to a detailed discussion of the different areas of the business of insurance which are regulated.

RATIONALE FOR REGULATION OF INSURANCE

The insurance product typically is a promise of future performance. The insured individual seldom knows whether the insurance product purchased by him provides him adequate coverage against the risk of a loss and whether the insurance company will provide him a prompt and fair settlement of losses, until he suffers a loss due to contingency insured against. And, this is a rather inconvenient time to find out that the insurance product does not give him full coverage against the risk or that the insurance company's service in terms of settlement of losses is not fair. The welfare of the insurance buying public also requires the continued existence of insurance companies in which people have invested their funds. The rationale for regulation of insurance industry, thus, has two primary aspects – protection of the consumers against unfair practices or market mis-conduct of insurers and protection of the consumers against losses arising from the insolvency of insurers. Hence, the primary objective of insurance regulation is understood to be safeguarding the interests of the consumers by facilitating the maintenance of financially sound insurance companies and ensuring fairness in the operations of insurance companies with respect to their customers.

In case of an insurance industry comprising only public sector companies or a public sector monopoly, regulation with the rationale stated above may not be necessary. For, it may not be the paramount objectives of a public sector entity to maximize its profits (or value of the form) or to guard its monopoly status, and also there may be inbuilt procedures in its operations to deal with the issues normally addressed by a regulator (Ranade and Ahuja 2000). However, when the insurance industry has private insurance companies competing with each other over similar lines of business in the same market, state regulation is considered to be necessary. As Chandler (2000) observes, "In almost all jurisdictions, government heavily regulates the business of insurance. To varying degrees in different states and nations, it uses its legislative and judicial branches to regulate solvency, under writing practices and contract structure. It likewise often distinguishes the business of insurance from other businesses regarding the extent to which separate enterprises must behave competitively rather than cooperatively". Because of certain factors peculiar to the business of insurance, like, the uncertainty about the cost of production for an insurer until the contract of insurance has run its full term, inability to distinguish between the risk types of potential customers costlessly, risks of overestimation of the returns from investment of surplus funds, etc., intense competition (or cut-throat competition, which many economists have used) between insurers can lead to insolvency of one or more of them. Thus, "while a good deal of government regulation is aimed at enforcing competition and preventing artificially high prices, government regulation of insurance has been aimed in the opposite direction: a basic goal has been prevention of cut-throat competition" (Elliott and Vaughan, 1972).

OBJECTIVES OF REGULATING INSURANCE INDUSTRY

In most countries with a reasonably long experience of a competitive insurance industry, the primary objective of regulation has been protection of the interest of consumers (Ranade and Ahuja, 2000). However, protection of consumer interest, though fundamental, is not the only objective that can be attributed to regulation of insurance. Keeping in mind the significance of insurance for the economy as a whole, and the needs for government intervention in the insurance industry specific to a developing country, various objectives can be assigned to regulation of the business of insurance. Also, we have discussed in the previous chapter that different groups of

economists adhere to different views regarding the need for government intervention in insurance industry. These differences can also translate into different views regarding objectives of regulation. Some of the important or oft-stated objectives of insurance regulation are as given below.

(1). The basic objective of insurance regulation is to ensure that insurers will have financial resources required to pay all claims from their customers as they become due; and that insurers will provide fair and prompt services to the customers in terms of the contract sold and settlement of claims. In other words, the fundamental objective of insurance regulation is to ensure the financial soundness of the insurance companies and their capital, reserves and investments; and to ensure that policyholders and beneficiaries are given fair and reasonable treatment by insurance companies and insurance agents (ibid.).

(2). As we have discussed in the previous chapters, insurance markets are vulnerable to the problems of asymmetric information arising in the form of moral hazard and adverse selection. Because of information constraints, such as, the inability of the insurer to observe the care taken by an insured to avoid a loss, and the inability to distinguish the potential customers on basis of their risk exposure level, the competitive market outcomes are not Pareto efficient but rather constrained Pareto efficient, at best. Also, as has already been stated, the benchmark of efficiency for an incomplete market with imperfect information (the type of markets most commonly found in developing economies) used in mainstream economic theory is the notion of constrained Pareto efficiency. Therefore, those adhering to the conventional notions of economic efficiency hold the view that regulation of insurance should be advocated if the competitive market fails to provide a constrained optimum, and the objective of the regulator should be to reach outcomes which are constrained optimum (since typically efficiency cannot be raised further).

However, in practice, even the most developed countries do not adhere to this view of regulating a competitive insurance industry with the objective of achieving 'efficiency' in the allocations in the market. This point becomes evident from the legal responses of the state to the issue of market fragmentation by insurers for coping with problems of adverse selection, which have come up in the developed countries, like, the United States. Chandler (2000) discusses the different types of legal

responses to the conflict between the goal of the insurers to control adverse selection and the goals of the government to ensure non-discrimination and safeguard interests of the public, which exist in practice.

In their attempt to control adverse selection, insurers frequently take resort to 'classification' of the (potential) customers in a market on the basis of one or more factor (variables) which may affect the risk exposure of an individual. One type of response has been that in which the government tries to evaluate the classifications used by the insurers (for setting different rates of premium as well as different levels of coverage for different customers) on the basis of the underlying actuarial principles. Examples of this type of responses are the laws (in the United States) that prohibit classification for automobile insurance based on marital status of the driver or different health insurance charges for disabled individuals, if such classifications are not supported by 'sound actuarial principles'. Such laws prohibit irrational (i.e., not based on sound actuarial principles) collective discrimination by insurers against disfavored groups. However, the actuarial principles for determination of risk exposure levels are also prone to errors. For, in the process of statistical analysis of expected losses of individuals vis-à-vis a number of observable variables relating to the individuals, certain variables might 'accidentally' correlate with expected losses. Also, keeping aside the applicability or validity of the conventional notions of economic efficiency, the government must fulfil its social responsibilities towards the citizens. Accordingly, one of the prevailing legal responses to the classification has been to prohibit classification, without any regard to the accuracy of actuarial principles or notions of efficiency. Examples of this type of responses, called as 'non-actuarialism' by Chandler (op. cit.), are the laws which prohibit the classifications based on gender or race for life insurance and annuity policies.

However, as the practice in the developed countries regarding regulation of insurance suggests, even when the government allows the insurers to take resort to classification of the customers, which in turn leads to fragmentation of the market on the basis of risk exposure of individuals, it does take care to provide insurance coverage to those individuals who get excluded from the market for voluntary private insurance. As regards the property-liability insurance industry in the United States, the market for each of the three largest types of coverage – automobile, homeowners and workers'

compensation insurance – generally has two components: the "voluntary market" and the "residual market" (Harrington, 2000). The voluntary market consists of policies that insurers sell voluntarily, while the residual market consists of policies that insurers are legally required to issue when buyers have difficulty obtaining coverage in the voluntary market. (For instance, in the case of auto insurance, most states in the U.S. use an assigned risk plan as the residual market. Drivers who have difficulty finding voluntary coverage can apply to the assigned risk plan. They are then assigned to insurers that must issue coverage under the terms of the plan. Assignments are made in proportion to each insurer's sale in the voluntary market [ibid.]). Also, in the U.S., all states regulate rates for the residual market.

Thus, in practice, the objective of protecting the interests of consumers far outweighs the objective of reaching through regulation an outcome that is 'efficient' in the sense used by conventional economic theory.

(3). As has been argued above, implementation of certain socially desirable measures can be an important objective of regulation of insurance industry. Government regulation may become necessary to ensure that the insurance companies provide certain forms of insurance, even when it is not very profitable for the firms to deal with those forms of business under the guidelines of the regulator. For example, employers' liability insurance and insurance coverage for third party motor accident injuries have been made compulsory in the United Kingdom (Holyoake and Weipers, 2002). Similarly, in some of the states in U. S., every insurer doing property-liability insurance business is liable to take up automobile insurance business (which has turned out to be a loss-incurring venture for many insurers). Thus, state regulation may be assigned the objective of safeguarding the interests of all consumers by making it mandatory for the insurance companies to take up certain lines of business, which could be unprofitable. Similarly, the regulator of insurance industry can take measures to ensure that the insurers do not discriminate against any section of the population on the basis of their geographical location which could be unfavourable for the insurers.

The objective of regulation, therefore, should be to ensure not only that the insurance companies treat their existing customers fairly and promptly but also that the insurance is available to the general public allover the country on a fair and equitable

basis. In fact, as we had noted in chapter – I, the argument made in favour of a liberal competitive insurance industry that such an environment will generally lead to lower premium rates, better risk coverage and better claim service is fallacious in that – a liberal competitive insurance industry tends to break down the larger pool of potential insured in search of smaller, less risky pools (which are more advantageous/ beneficial for some, while excluding others); and premiums within these smaller pools can be kept lower and claims service higher, but only for those fortunate enough to be included. Thus, in a competitive insurance industry, the insurers tend to fragment the society on the basis of risk exposure resulting in exclusion of people more vulnerable to losses, from institution of insurance. Keeping in mind the necessity of insurance for an individual (discussed in chapter - I) and the basic function of a system of insurance (of pooling risks and distributing the losses of a few among a sufficiently large number of people), one of the important objectives of regulation of insurance industry should be to prevent the fragmentation of society by the insurers or at least to ameliorate the adverse consequences (for the society) of such fragmentation practices. This objective of regulation should be of paramount importance in those countries where the social security system is weak.

(4). Apart from controlling unhealthy price competition (from the point of view of financial soundness of the companies) between the insurers, one of the objectives of regulation could also be to promote co-operation among the insurers in the areas of estimation of expected loss posed by policy-holders and calculation of actuarially sound premiums; for, there exist significant economies of scale in production of information needed to prevent insolvency of insurance companies (Chandler, 2000). As Chandler (op. cit.) observes, individual insurers, even large insurers operating in multiple lines of business, may lake adequate internal historic data to perform the necessary analyses with confidence, and, this inability extends even to projections of future losses on future policies.

In an economy with low levels of educational attainment, low levels of sophistication in the processing of finer points of financial contracts, and a weak contract enforcement regime, such as, India, one of the objectives of regulation could be standardisation of insurance contracts (Ranade and Ahuja, 2000). Since in such an economy, the complexities of an insurance contract can create strong disadvantages

for a large number of buyers of insurance vis-à-vis the insurance companies (which draft the policy forms). Standardisation of contracts (i.e., policy forms) will help the buyers understand the merits and demerits of the policy they consider for purchase and compare across different policies being offered in the market.

However, as Ranade and Ahuja (op. cit.) point out, standardisation impedes product innovation, and hence, the requirements of standardization may gradually be brought down over a long period of time as consumers become more aware of the intricacies of insurance contracts.

(5). Booth and Stroinski (1994) note that one of the objectives of government regulation of the insurance industry could be to promote certain economic policy objectives. Also, regulation of insurance may be assigned the objective of influencing the level of private savings, pensions, etc.

(6). We must note here the concern raised by Carmichael and Pomerleano (2002) regarding what should not be the objective of regulation of insurance industry. The objective of regulation should not be to shift risk (either knowingly or inadvertently) from the insurers to the government. Most prudential regulators work under the principle that the primary responsibility for prudence rests with the boards and management of the insurance companies, not the government.

AREAS OF REGULATION

From our discussion of various objectives of regulation of insurance, we may conclude that the fundamental objective of regulation deals with the protection of interests of the consumers, which has two aspects – protection against losses that could arise because of insolvency of insurers and that against losses which could be caused by unfair practices and market mis-conduct by the insurers. We can also say that these twin objectives of protection of insurance buying public can be expected to be found everywhere in practice. Accordingly, the primary functions of insurance regulators are performed under two main categories of regulations, viz., solvency regulation and market regulation (Ranade and Ahuja, 2000). Apart from solvency regulation and market regulation, there exists another type of regulation which can be

called structural regulation. However, it may be mentioned here that many of the regulations falling under these three domains are inter-linked, and therefore these three broad areas of regulation of insurance cannot be perceived as watertight compartments. Also, the bulk of the regulations laid down in most of the regulatory regimes for insurance across different countries apply to all of the different lines of insurance business (like, life insurance, health insurance, property and liability insurance as well as reinsurance). However, there may be some specific tools or techniques of regulation for each of these different lines of business albeit driven by the same objectives.

Structural Regulation

This type of regulation usually imposes restrictions on the kinds of business (or the lines of business) activities that can be carried out by insurance companies. Many countries have imposed lines of business restrictions on the different types of companies that operate in the financial sector, such as, insurers, banks, securities firms and mutual funds, etc. When the lines of business are restricted, there are separate regulatory authorities for the different kinds of companies. For instance, in India, the approach to regulation of the financial sector is the 'pillars approach' (OECD, 1998), under which there are separate regulatory authorities for the markets of insurance (the Insurance Regulatory and Development Authority), banking (the Reserve Bank of India) and securities (the Securities and Exchange Board of India). Since line of business restriction can be overcome by forming subsidiaries or letting a venture be owned by another company, line of business restrictions can also be strengthened by additional restrictions on ownership of companies.

In many countries, neither the banks are permitted to directly produce insurance products nor are the insurers allowed to produce banking products. However, banks may be allowed (as in many OECD countries) to distribute insurance products of insurers, but insurance companies are usually not allowed to even distribute banking products.

The main regulatory concern behind this type of structural restrictions has been that the insolvency of a company in one line of business may cause its insolvency in the

other (Chollet and Lewis, 1997) [as referred to in Mahal, 2002]. The argument put forward against this type of structural regulation is that – there is now a considerable overlap in products sold by three branches of the financial services industry (i.e., banks, insurers, securities firms); structural regulations (or restrictions on line of business and ownership of companies across different lines) limit exploitation of economies of scope in production, and increase the cost of bundling products that cross sectoral boundaries; and hence, separation of financial markets through regulation could be diluted by allowing firms in one sector to enter another sector through a subsidiary; and competing products (in the financial services industry) with similar characteristics should face similar regulatory requirements, independent of the sector in which they are produced (Ranade and Ahuja, 2000).

However, a dilution of the restrictions on the entry of other financial companies into the business of insurance as well as entry of insurers into other financial services would expose the insurance industry to an additional source of market failure, which is 'systemic instability'. Systemic instability arises where the failure of one firm to honour its promises leads to a general panic, as individuals fear that similar promises made by other firms also may be dishonoured, which can lead to a crisis when contagion of this type causes distress or failure of otherwise sound firms. Contagion risk is usually regarded to be very high among the deposit taking institutions, since there is a conflict inherent in their promise to transform their illiquid assets into liquid liabilities (Carmichael and Pomerleano, 2002). Such a promise can be honoured under most circumstances, provided sufficient liquid reserves are available, either on balance sheets of the institution or through credit lines. However, when a sufficiently large proportion of depositors simultaneously demand convertibility, the promise cannot be honoured without outside assistance. Since this weakness potentially exists for all such deposit takers, a crisis of confidence in one institution can quickly spread to others. In case of companies which are prone to contagion risk, the systemic instability could also be caused by problems in the payments system through which obligations are settled between financial companies, stock price collapses, or even the failure of a single large institution which is involved in a complex network of transactions. Thus, in an insurance industry, if the firms are engaged not merely in insurance activities but also in those kind of financial services which provide a systemic threat, a systemic instability in the business of some financial product other

than insurance can lead to the insolvencies of subsidiaries (doing business in that financial product) of many such players who were otherwise financially sound both in their insurance business and in the business of that particular product.

Then, as Chollet and Lewis (op. cit.) point out, the failure of an institution in one line of business (other than insurance) may cause its insolvency (or aggravate its financial problems) in insurance business. Thus, a removal or dilution of the lines of business restriction vis-à-vis the business of insurance can make the insurance industry more fragile.

It may be appropriate to note here that an insurance company per se does not provide any systemic threat. For, insurance companies are not characterised by the highly liquid liabilities that confront deposit takers; and even though insurers may depend on new premiums to generate profits, the loss of new premiums in the event of market concerns is unlikely to cause the failure of an otherwise sound insurer, nor is it likely to cause the failure of other sound insurers (Carmichael and Pomerleano, 2002).

Another important concern within the domain of structural regulation is the adverse consequences that could arise as a result of the mergers of financial intermediaries or association of financial intermediaries and non-financial corporations. As Chandrasekhar (2004) observes, in the context of financial liberalisation in Latin America (which had started in the 1970s), the mergers of financial intermediaries and association of financial intermediaries and non-financial corporations resulted in a strengthening of oligopolistic power of the financial conglomerates, and financial intermediaries that were a part of the conglomerates allocated credit in favour of companies belonging to that group. Similar developments, in case insurance companies, can not only lead to inefficient allocation of credit in the economy but also to imprudent investments resulting in insolvencies of the insurers. Also, the ability of the regulatory authorities to ensure protection of the interests of consumers can get weakened considerably with the rise in oligopolistic power of the financial conglomerates. These concerns make a strong case not only for line of business and ownership restrictions in the insurance industry but also for antitrust regulations for the insurance companies.

Solvency Regulation

The main concern of the regulators of a competitive insurance industry in this area of regulation, is to maintain a balance between the requirements of financial stability and scope for competition in the industry. This is because, very strict financial standards may leave few insurers in the market, and at the same time, in the absence of prudential regulation of the solvency and capital adequacy of the insurers, intense competition (or cut-threat competition) between the firms may lead to financial instability and insolvencies.

Extreme competition, especially price competition between insurers, and imprudent investment decisions by the managers (in pursuit of profits in the short run) can both harm the financial health of the company. This problem gets aggravated because of information (about financial health of insurers) being costly for the insureds and 'agency problems'. (A note on the agency problem in insurance may be appropriate here. The system of insurance requires an expectation by the insured that the insurer will actually be able to indemnify him for losses when the events occur at some point in time in the relatively near future (property-casualty insurance) or in the distant future (life insurance). The agency problem arises because of the existence of incentives for insurers with limited liability to invest in high risk ventures - in that the likelihood of indemnification of losses to the insured is hardly assured. Now, such an incentive (for investing in high risk ventures) exists because "the insurers capture all the upside of a favourable materialisation of the risk while they are able to shift part of the downside of an unfavourable materialisation of the risk onto the insureds" (Chandler, 2000). While economic theory suggests that insureds may be able to constrain this 'agency cost' by use of monitored conditions in contracts or through bonding (mutual ownership), few individual insureds can structure the complex arrangements needed to achieve this end (ibid). These problems are particularly serious with respect to insurance because non-payment to the insured occurs after the insured has suffered a loss, which could be of a very high magnitude also.

In order to contain the risk of insolvency of the companies, regulators require the insurers to meet minimum capital requirements (which establishes a floor for insurers to enter the market and remain in operation) and to maintain adequate levels of surplus of assets over liabilities (or adequate levels of solvency, which measures the

difference between the assets and liabilities of an insurer). The rationale for using capital adequacy and solvency margin requirements is that capital and reserves with the insurer can provide a cushion against the financial problems that can arise because of an unexpected increases in the liabilities and/or decreases in the value of its assets. Also, in the event of insolvency of an insurer, its capital can be used to fund rehabilitation or liquidation with minimal losses to policy holders and claimants.

The various tools or techniques of regulation used under the domain of solvency regulation are as given below.

(1). In practice, the requirement of a certain minimum level of 'solvency margin' for the insurance companies has been widely used by the regulators. This approach to solvency regulation takes into account the insurer's size and its risk profile. Solvency margin usually expresses the surplus capital of a company (i.e., assets less of liabilities) as a proportion of its net or retained premiums (i.e., gross premium incomes less of reinsurance payments). By enforcing a certain minimum value for this solvency margin, the regulators try to ensure that for a given level of surplus capital available with the company at a given point in time its net/retained premiums cannot exceed beyond a certain volume. Apart from the use of this solvency margin as a cushion against financial problems, another reason behind this regulation (of solvency margin) is that restrictions on the rate at which a financial intermediary, such as insurer, can engage in new borrowing decreases the likelihood of insolvency and preserves the ability of monitoring agencies to provide early warning of problems (Mayerson, 1969) (as referred to in Chandler, 2000).

(2). The solvency margin, instead of using net/retained premiums, can also use average of claims incurred by a company over a given period of time. For instance, in the European Union, the solvency margin applicable for an insurer is higher of that calculated on the basis of claims (23-26 percent of average claims in the last 3-7 years) or that calculated on the premium basis (16-18 percent of retained premiums) (Mahal, 2002). Also, under the European Union regulations, a reduction is allowed for those companies which have taken reinsurance, but that reduction allowed is up to a maximum of 50 percent of the original solvency margin.

(3). In the calculation of the assets of an insurer for the purpose of determination of solvency margin, regulators can also restrict the inclusion or exclusion of certain assets (for instance, the regulator may exclude assets held in the form of investments in related companies or loans to the board or senior management of the company) (Carmichael and Pomerleano, 2002). Apart from restricting/specifying the range of assets and liabilities to be included, the regulators may also take into account their method of valuation. As Carmichael and Pomerleano (op.cit) point out, liabilities can also arise with respect to outstanding claims (i.e., claims against existing policies that have yet to be filed) and future claims (i.e., claims against existing policies that have yet to occur, as of the time of valuation), and variations in the measurement of these liabilities can have a material impact on the measurement of the insurer's insolvency. Regulators of insurance can set standards for the valuation of these liabilities in consultation with the relevant accounting standards authority for the country.

(4). Within the domain of solvency regulation, the regulators may require the insurers to submit financial reports, annual reports, conduct audits and periodic reviews of the financial conditions of the insurers. Also, insurance regulators may have the power to change the management and financial practices of a particular company, if the need arises.

(5). The regulators also restrict the nature of investments that can be undertaken by an insurance company.

(6). One prominent development in the area of solvency regulation, in the last decade, has been the adoption of the risk-based capital (RBC) approach in several countries. (including the Unites States, Canada, Norway and Australia), replacing the traditional approach to solvency regulations which (as has been discussed above) bases the regulatory capital requirement (for an insurer) on one or a combination of the liability measures only. In contrast to the traditional approach (to measure an insurer's risk-profile), the risk-based capital approach recognizes risk as arising not only from uncertainty in the valuation of liabilities but also from uncertainty in the valuation of assets. Accordingly, the risk-based-capital approach usually sets more stringent conditions on the companies in terms of their regulatory capital requirements.

Market Regulation

Different kinds of regulatory measures aimed at ensuring that the insurance companies are treating the insurance buying pubic in a fair and equitable manner can be thought of as falling under this broad area of regulation. Some of the important instruments of market regulation are as given below.

(1). Rate Regulation

Rate regulation in the insurance market may impose a price floor, or a price ceiling, or both on premiums. By imposing a price floor, the regulators may attempt to ensure that premiums changed by insurers are 'adequate' so that excessive price competition does not drive one or more insurers out of the market. On the other hand, price ceilings may become necessary even in a competitive insurance industry keeping in mind the-facts that insurance coverage has come to be regarded as essential for every individual, the insurance buying public may not be able to compare the rates charged for similar levels of coverage across different companies (leaving scope for the insurers to charge excessive prices), and also the insurers may indulge in collusive behaviour to change excess prices in any one or more lines of business. Regulators may also control the rates directly by requiring prior approval of the rates (along with the policy forms) and any increase in the rates changes. As was noted in the discussion of the objectives of regulation, the regulators may require that premiums should not be 'unfairly discriminatory'- in the sense that there should be a sound actuarial basis for discriminating between different customers in terms of the premium charged for similar levels of coverage. However, the tendency of a competitive insurance industry being towards fragmenting the entire pool of potential customers into smaller groups on the basis of their risk exposure and excluding the 'substandard' customers from the market for voluntary private insurance, regulators may requires the insurance companies to cater to those excluded from the voluntary private insurance market at rates determined directly by the regulatory authorities.

(2). Marketing and Language of Insurance Contracts

This category of regulation requires the insurance contract to be written in a language that is easy to understand, unambiguous and not misleading. Regulatory measures are also taken tot check unfair trade practices such as misrepresentation, discrimination,

inducements (to insureds /agents), and so on. Also, the insurance intermediaries are regulated through licensing as well as consumer protection regulation.

(3). Claims Settlement

Regulators may impose penalties (such as, an interest to be paid to the claimants) on the insurers for delay in the settlement of claims.

(4). Exit of an Insurer

Regulations in this area try to ensure orderly exits of insurers from the market. The insurer, planning to leave the industry, may be required to give a timely notice to the regulator and submit plans for payment of all liabilities prior to the exit date (Mahal, 2002).

(5). Grievance Redressal

One of the important aspects of market regulation is the requirements for insurance companies to set up proper mechanism for redressal of consumer grievances as also setting up an institution for dispute resolution through arbitration. The effectiveness of such institutions would depend on a number of factors, such as, awareness of the insureds about their rights and options, accessibility of the dispute resolution institutions to the public in general, and time taken to deal with the grievances and enforce the awards made by these institutions.

(6). Insurance Guarantee Funds

In many countries, Guarantee Funds reimburse claimants of insolvent insurance companies for losses not covered by the remaining assets of the insurers. For instance, in the United States, Guarantee Funds operate at the state level and obtain funds (to pay claims) by taking contributions from the solvent insurers in proportion to their revenues in the state. Guarantee Funds can also be formed by taking the premiums of the insurers on a regular basis. Guarantee Funds seem to be of crucial importance from the point of view of interests of the insureds. However, the argument put forward against such funds is that it takes away the incentive for the public to depend on financially strong, well-run companies, and that it reduces the incentive of

insurance firms to be more prudent about their investment and business decisions (Ranade and Ahuja, 2000). But the problem of moral hazard arising from the existence of a Guarantee Fund are partially solved by not paying the full liabilities of the insolvent insurer to the insureds. Also, in a country with less awareness among the general public about the intricacies of insurance, for instance, in a developing country like India, the existence of a Guarantee Fund cannot be expected to make much of a difference to public monitoring of the operations of the insurers. Hence, for a country like India, an insurance Guarantee Fund may have more benefits than costs.

(7). Self-Regulation by the Industry

An important issue relating to market regulation is about the mode of such regulations. Measures of market regulation can be formulated and implemented through the government regulatory authority, or through self-regulation by the insurers, or by a combination of both the regulatory authority and the representatives of insurers. The argument in favour of self-regulation is that since the insurance industry has better information than a government regulatory authority self-regulation by the industry can be more effective, and that self-regulation (by shifting the cost of regulation onto the industry) costs less than formulation and implementation of market regulations by the government authority. However, this kind of an argument completely ignores the fact that objectives of market regulation may never be achieved in an environment of self-regulation. In fact, the ability to attain the goals of regulation, rather than the cost of regulation, should be the parameter to judge the different modes of market regulation.

Chapter III

A SURVEY OF INSURANCE REGULATION IN SELECTED COUNTRIES

This chapter presents a survey of regulation of insurance industry in the Unites States of America, the European Union, Japan, China and Poland. In terms of the practice followed in different countries, the regulatory rules for insurance companies are much less uniform than those for banks (Dewatripont and Tirole, 1994) As was noted in the previous chapter, different countries use their legislative and judicial branches to different extents for regulating the business of insurance. While some of the developing countries (for instance Chilie) and emerging market economies (e.g., some of the transition economies in Europe) have set up a relatively liberal regime of regulation, many developed economies (most notably, Japan) have relied upon relatively strict regulation of insurance. However, no generalisation can be made as regards the level of economic development of a country (as also the level of maturity of its regulatory regime for insurance). Accordingly, the purpose of the survey presented in this chapter is to gauge the range of options available (in practice) for an insurance regulatory regime and to draw lessons from the experiences of the selected countries, which could be of much relevance for assessing the insurance regulatory regime of India.

The insurance markets in the U.S. and the European Union are the two largest competitive markets for insurance, characterised by the presence of a sufficiently large number of private insurers competing with each other in identical lines of business. However, the regulatory authorities in neither of the two seem to adhere to the view that the force of competition can discipline the insurance companies and ensure the safeguarding of the consumers' interest. In European Union, the guidelines on solvency regulation are similar for all member countries, but market regulation falls mainly under the domain of the individual countries. As a result, the strength of the regime of regulation varies across different member countries. However, in the

United States, the regulators have tried to address most of the problems arising in the private insurance market with the clear cut objective of protecting the interest of the consumers, and, as a result, have implemented a series of regulatory measures which check competition in the market and put stringent restrictions on the insurance companies. Japan, on the other hand, has protected its insurance industry from a liberal and competitive environment for long through very tough regulatory measures. The remarkably high levels of insurance penetration (i.e., premiums expressed as a % of Gross Domestic Product) and insurance density (i.e., premiums per capita) in Japan provides a sharp criticism of the arguments put forward, by the advocates of deregulation/liberal regulation of the insurance industry that a liberal regulatory regime is essential for achieving a matured insurance industry which in itself will be much less prone to market failure. China's experience with liberalisation and regulation of insurance shows a very cautious approach to replacing the existing nationalised insurance industry with a competitive one and towards allowing foreign insurers entry to the domestic market, both of which can be detrimental for a developing economy when these changes are implemented hastily. Finally, Poland offers an important as well as interesting case of a country undertaking full-scale liberalisation of the existing nationalised insurance industry accompanied with a liberal regulatory regime, and then paying the price for it.

THE UNITED STATES

(1). In the United States, constitutional authority to regulate insurance belongs to the federal government, under its authority to regulate interState commerce. However, through the Mc Carran-Ferguson Act of 1945, the U.S. Congress agreed to leave the responsibility and authority for insurance regulation to the States as long as the Congress considered State regulation to be adequate (Jones and Long, 1999). The Congress retained the right to enact insurance legislation if it feels that State regulation is inadequate or not in the public interest, and a number of federal laws have been enacted that regulate certain aspects of the insurance business.

(2). Every State and territory has a chief government official who is responsible for regulating insurance companies and the market. While these insurance commissioners

in most of the States are appointed by the Governor (or by a regulatory commission) for a set term subject to legislative confirmation, twelve States and one territory elect their insurance commissioners who have more independence than the appointed commissioners (Grace and Klein, 1999). The insurance commissioners are required to act within the framework of insurance laws enacted by the legislature. Also, the regulations promulgated by the commissioner are subject to review and approval by the legislature in some States.

This structure of regulation is noteworthy in that it ensures active participation of the legislature (in the States) in the insurance regulatory regime.

(3). Due to resource constraints and the difficulties in supervising companies operating in multiple jurisdictions, the States have delegated the primary authority for solvency regulation to the domiciliary commissioner (i.e., the commissioner in the State where an insurer is domiciled or incorporated), but, at the same time, non-domiciliary commissioners can exert considerable influence on non-domiciliary insurers through their authority to grant license to each insurer operating in their jurisdiction (ibid). In fact, this requirement for insurers as well as agents to obtain a separate license for operating in each State (i.e., an insurer or an agent needs 50 separate licenses to be able to sell insurance in all 50 States) is one of the core strengths of the insurance regulatory regime in the U.S. Apart from enabling the regulators to exercise considerable degree of control over the market conduct by insurers, this measure has also made the entry of foreign insurers more difficult.

(4). Fixed capital requirements for insurers, across the different States, range from $500,000 to $6 million, and these minimum capital requirements are supplemented by additional requirements relating to solvency (Skipper and Klein, 1999). The National Association of Insurance Commissioners (NAIC) [a private non-profit association of the chief insurance regulatory officials of the 50 States, the District of Columbia, and the four territories], through which State regulators set nationwide standards, facilitated the adoption of risk-based capital (RBC) requirements for monitoring the solvency of insurers starting from the early 1990s. As we had noted in the previous chapter, this RBC approach takes into account the risks to an insurer (not only from the uncertainties associated with the estimation of liabilities but also) from uncertainties associated with the valuation of its assets. The regulations relating to

solvency and capital adequacy heavily favour low-risk assets (e.g., bonds) over high-risk ones (e.g., equity) (Dewatripont and Tirole, 1994). The insurers are also subject to restrictions in areas, such as, investments, transactions with affiliates, and the use of managing general agents, and they are required to file detailed annual and quarterly financial Statements prepared according to regulatory accounting standards with annual independent audit opinions and actuarial certification of reserves (Skipper and Klein, 1999). Also, the regulators have broad powers of changing the management and financial practices of an insurer, should the need arise (Mahal, 2002).

(5). There were roughly 8000 insurance companies (belonging to approximately 1000 insurer groups) domiciled in the U.S., and the U.S. property-liability and life-health insurers combinedly collected roughly US $700 billion in premiums annually and controlled approximately US $3 trillion in assets, in 1999 (Grace and Klein, 1999). However, the largest insurers command an important share of many markets in the U.S. (Skipper and Klein, 1999).

It may be noted here that, the U.S. financial services sector continues to be segregated, although the extent of separation has been reduced over time.

(6). While the approach to regulation of solvency is similar in the States, there exists considerable diversity among the States in the areas of regulation of rates, policy forms and market conduct. Approximately, half of the States use prior approval rate and policy form regulation for the personal lines of insurance (ibid). As regards commercial lines of business, most States use prior approval rate regulation only for workers' compensation and medical malpractice insurance. As regards life insurance, though life insurance premiums are almost never regulated, life policy forms are reviewed by the regulatory authorities.

One of the important facts to be noted in case of insurance regulation in the U.S. is that rate regulation has been historically an important element of regulatory measures (all through the twentieth century) despite remarkable growth (or maturity, in the jargon of the advocates of deregulation) of the insurance industry in the country. As Harrington (2000) observes, insurance rate regulation in the U.S. dates back to the early twentieth century and its practice became widespread after the enactment of the McCarran-Ferguson Act in 1945. After 1945, as the authority and responsibility for

regulating insurance was passed on to the States, most States enacted prior approval rate regulation of property-liability insurance rates. They required or strongly encouraged all insurers to charge the same rates, set by rating bureaus. The requirement for using bureau rates was gradually relaxed during the 1960s, and then in the decade of 1970s, a number of States began to deregulate rates for some lines of business. However, many of the States still continue to regulate rates for private passenger automobile insurance, homeowners' insurance and workers' compensation insurance. Some of the States also regulate rates for other lines of business in the properly-liability sector. And, regulation of health insurance rates has expanded in the U.S. in recent years (ibid).

As we had discussed in the previous chapter in the context of regulatory response to fragmentation of the market by insurers in the pursuit of insuring only good risk types; the market for automobile, homeowners and workers' compensation insurance generally has two components: the 'voluntary market' and the 'residual market'. While the voluntary market accepts only those customers who are perceived to be of good risk type by the insurers, the residual market is meant for all those consumers who get excluded from the former. The regulatory authorities in the U.S. make it mandatory for the insurers operating in the voluntary market to provide insurance policies to the participants in the residual market and at rates stringently regulated by the authorities. In the voluntary market also, as was discussed above, many States use prior approval rate regulation.

(7). Reinsures domiciled in the U.S., with the exception of solvency oversight by their domiciliary jurisdiction, are usually not subject to direct financial and market regulation. However, the reinsurers are regulated indirectly through the States' regulation of the primary insurers that are ceding business to reinsurers (for instance, whether a ceding insurer can claim credit for reinsurance on its balance sheet is conditioned on whether its reinsurer meets certain financial and/or trust requirements imposed by the regulators) (Grace and Klein, 1999).

(8). In the U.S., the insurance contracts issued by the insurers are covered (or insured) by quasi-governmental Guarantee Funds which exist at the State level. The losses incurred when an insurer becomes insolvent are in principle paid by other participating insurers. While the contributions for the Guarantee Funds are collected

from the solvent insurers in proportion to their volumes of business, these Funds are implicitly backed by the State Governments, giving policyholders reasonable certainty that their claims will be paid even if their insurance company goes broke.

THE EUROPEAN UNION

(1). In the European Union, insurance regulators in each country enforce country-specific market regulations, while the solvency regulation standards are similar for all member countries.

(2). Solvency regulation in the E.U. rests on three pillars: capital adequacy requirements, asset portfolio restrictions, and intervention by the regulator (restructuring plan, mandatory closure, sale or absorption) in instances of violation of these requirements (Dewatripont and Tirole, 1994). Portfolio restrictions insist on the marketability of assets and on avoiding excessively concentrated risks (e.g. no more than 10% of assets in a single construction project, or no more than 5% of assets in financial securities of a single firm) (ibid). However, the E.U. approach to solvency regulation is identified with the traditional approach, as distinct from the risk-based capital approach of the U.S.

In the European Union, the minimum requirement of solvency margin for an insurer is the higher of the solvency margin calculated on the basis of claims incurred by the insurer (23-26 percent of the average claims incurred in the last 3-7 years) and that calculated on the basis of premiums (16-18 percent of retained premiums in a year) (Mahal, 2002). A reduction is allowed for taking resort to reinsurance, but the reduction never exceeds 50 percent of the original solvency margin calculated (irrespective of an insurer taking huge amounts of reinsurance). The limit on using reinsurance for calculating solvency margins is to avoid creating incentives for the insurer to take on more risk (ibid).

(3). Historically, regulatory philosophies have varied enormously among the EU countries—while the United Kingdom, the Netherlands, and Ireland have mostly had a flexible or liberal regulatory regime; most other E.U. countries, especially Germany and Austria, have exercised strict regulation, focusing not merely on matters of

financial prudence of insurers but also on detailed oversight of policy terms and conditions, pricing and market order (Skipper and Klein, 1999).

(4). The licensing requirements, in the E.U., are liberal in the sense that an insurer licensed to write business in one E.U. country can write business in any other E.U. country without the need for authorisation from the host country. This single-license concept requires prudential oversight by the insurer's home country only, and the host-country regulators are expected to rely upon their counterparts in other E.U. countries in the matters of prudential oversight.

(5). As regards rate regulation, the E.U. guidelines constrain the ability of the member countries to strictly regulate premiums or policy forms. In case of life insurance, the host country may require disclosure of the actuarial aspects of premium and reserve calculations, but not as a condition for market entry. For non-life insurance, the host country may require information disclosure that proves that the insurer is complying with its consumer protection laws.

JAPAN[1]

(1). The insurance industry in Japan has been subject to strict regulation since long. Japan's Ministry of Finance has performed the functions of insurance regulation.

(2). Historically, Japanese insurance regulation has restricted entry for new insurers into the market and restricted competition between the existing insurers in the industry. Japanese insurance regulation is based on a 'convoy' philosophy, under which the convoy members/insurance companies move no faster than the weakest or least innovative insurer. Price competition has been severely restricted, with insurers generally charging the same rates. This practice of charging uniform rates has ensured that the financially weakest insurers would survive in the market. Prevention of insolvency has been given utmost importance by the regulators. In order to ensure market stability, both prices as well as insurance policy forms have been subject to stringent regulations. There have also been criticisms of Japan's insurance regulation as lacking transparency.

[1]The material for this section has been drawn mainly from Skipper and Klein (1999)

(3). Until recent times, application approval for foreign insurers was conditioned on the (foreign) insurer introducing a product not yet offered in Japan. However, in response to the criticisms (of lack of transparency in the regulatory process and discouraging competition) leveled against it, the Ministry of Finance, in the recent past, has agreed to process applications for licenses without delay and to inform applicants of the reasons for any application's rejection. The Ministry of Finance has also initiated measures to liberalise the rate regulations in the insurance market. However, it must be noted here that Japanese rate-setting organisations and most of the insurers operating in the country did not welcome this liberalisation of rate regulation measures.

(4). Despite the changes initiated by the ministry of Finance, foreign insurers control a very small share of the market (as of 1999, foreign insurers controlled only about 4 percent of premiums in the Japanese market), and they complain that their ability to compete in the Japanese market remains blunted.

(5). In the context of the arguments put forward by advocates of a liberal, competitive insurance market that only such an environment can ensure substantial growth of the insurance industry; it is very important to note that Japan's performance in terms of the two commonly used parameters, the insurance penetration (which is premiums expressed as % of Grace Domestic Product) and insurance density (which is premiums per capita), is as remarkable as that of the United Kingdom (oft-cited as a country that has benefited from a liberal insurance regulatory regime). As compared to the insurance penetration of the U.K., in 1999 and 2000, at 13.35% and 15.78% respectively, the corresponding figures for Japan were 11.17% and 10.92% (IRDA, second Annual Report 2001-2002). Similarly, while the insurance density of U.K., in 1999 and 2000, was at US $ 3244.3 and US $3759.2; the corresponding figures for Japan were US $3908.9 and US $3973.3 (ibid.)

CHINA[2]

(1). China's State-owned insurer Peoples Insurance Company of China (PICC) had a monopoly in Chinese insurance market since its inception in 1949. However, during 1959 to 1979, PICC had suspended its domestic operations as insurance was considered to be a capitalistic concept under 'Great Leap Forward' (Ranade and Ahuja, 2000). In order to improve competitiveness of China's insurance industry, the government broke the monopoly power of PICC by allowing the entry of Ping An Insurance Company (PAIC) in 1988 and of China Pacific Insurance Company (CPIC) in 1991. PAIC was initially capitalized by the China Merchants and Industrial Bank and the General Bank of China. However, later it attracted other investors including Morgan Stanley and Goldman Sachs. CPIC (China Pacific) was established by the Bank of communications.

(2). PICC, PAIC and CPIC are the only three insurance companies in China which are licensed to operate throughout the country for all classes of life and non-life business. Apart from these three national insurers, China has some regional insurers (7 in 1999) which are not allowed to operate outside certain specific regions like Shanghai (and later Guangzhou). The three national insurers have branch offices all over the country. PAIC (Ping An) is primarily in the non-life sector, and PICC has been divided into three companies, targeting life insurance, property insurance, and reinsurance.

(3). The Chinese government, experimenting with foreign insurers, allowed American Insurance Group (AIG) to set up a branch in Shanghai in 1992, and Tokyo Marine and Fire Insurance in 1994. In 1995, Guangzhou was made the second pilot area to allow foreign insurance operations and AIG was given the license to set up two branches there for life and property insurance respectively.

(4). Because of its cautious approach towards allowing insurance companies to underwrite risk, the Chinese government could afford not to have an appropriate regulatory authority in place till 1995. Prior to 1995, the Chinese government passed a series of notices and administrative orders to regulate the insurance business in the country. However, introduction of competition in the market without proper

[2] The material for this section has been drawn mainly from Lancaster (2001), the Chubb Corp. (2001), and Ranade and Ahuja (2000)

regulation did lead to unhealthy competition in some lines. In fact, the lack of solvency control regulations led to insolvency of Yongan Property Insurance Company within nine months of its establishment.

(5). In 1995, the Insurance Law of China was promulgated, which led to the formation of China Insurance Regulatory Commission that became independent (by cutting off links with the State-owned PICC) in 1998.

(6). China, even while encouraging competition in the insurance market among the existing (mainly domestic) insurers, has protected its market from competition by foreign insurance companies. China has encouraged the growth of domestic insurance companies and restricted the entry and operation of foreign insurers to a significant extent. Since China was not a member of WTO until very recent times, it could afford to adopt differential policies for the foreign insurers operating in the country [which is a deviation from the clause in General Agreement on Trade in Services (GATS), which requires every member country to provide 'national treatment' to foreign firms]. The restrictions on foreign insurers have included restrictions on ownership, capital, license, type of line (of business), investments and geographic area of operation.

It must be noted here that the cautious approach towards competition and foreign participation, adopted by China, does not seem to have affected the growth of its insurance industry. For, during 1985 to 1995, the average annual growth rate of insurance premium (written in the country) was as much as 37 percent.

(7). The Insurance Law (of People's Republic of China), promulgated in 1995, has provided for a tough regulatory regime for insurance in the country. The Chinese regulation of insurance requires maintaining technical reserves and other statutory funds, satisfying solvency requirements, making prudent investments (there are strong restrictions on investments), compulsory reinsurance and compulsory information disclosure. However, certain provisions of the Chinese insurance regulation regime deserve special attention, some of which are discussed below.

(8). The Insurance Law of 1995 requires that "the basic insurance clauses and premium rates for major types of commercial insurance shall be formulated by the financial supervision and regulation department (FRSD). The insurance clauses and

premium rates for other types of insurance formulated by an insurance company shall be filed with the FRSD" (Article 106, Insurance Law of the People's Republic of China, 1995). Thus, China opted for strict rate regulation under a tariff system, as also strict regulation of the policy forms. Although, this type of regulation slows down innovations in the industry, it serves a very important goal of ensuring market stability (which in turn protects the insurance buying public) and enabling the potential customers to compare across the policies offered by different insurers. This kind of regulation seems to be more important in case of emerging markets in insurance.

(9). In countries like China and India, characterised by huge population and a vast geographic area, insurance intermediaries (agents and brokers) can be expected to play a key role in the insurance industry, both from the point of view of growth of business and protection of interest of the public. (By the end of 1995, there were about 2 lakh insurance agents in China, who collected about 40 percent of the total insurance premium in China). The Chinese regulatory regime takes into account the need for proper regulation of the agents' and brokers' operations. Accordingly, it has been laid down in the Insurance Law that the insurer shall be held liable for the acts of its insurance agents, and that an insurance broker shall be liable for damages or losses caused to the applicant or the insured due to the negligence of the insurance broker.

(10). As regards investment of funds, the insurance companies are required to apply their funds "in a conservative, sound and safe manner and ensure that the value of its assets is maintained and increased". Also, the investments of an insurance company have been restricted to bank deposits, trading of government and financial bonds, and other forms of investments as will be stipulated by the regulatory authority.

(11). If an insurance company violates the provisions of the Insurance Law and has seriously threatened its solvency, then the Chinese regulatory authority has the power to implement a take-over of that insurance company. As Stated in the Insurance Law (Articles 113-116), the purpose of such a take-over would be to adopt measures which are necessary to protect the interests of the insured and resume the normal operation of the insurance company.

POLAND[3]

Booth and Stroinski (1994) provide a detailed account of Poland's insurance market liberalisation in 1990, accompanied by a liberal regulating regime (taking very much into account the European Community requirements), and the development in the insurance market following this liberalisation. The Polish insurance market was liberalised significantly in July 1990. Till that time, under the Communist system, the State insurer PZU had almost a monopoly over the insurance market.

(1). In 1991, there were three major players in the Polish insurance industry-two nationalised insurance PZU and Warta, and a private insurer Westa (established in 1988 as a cooperative). Then, in terms of premium income, PZU had 73.9% of the Polish insurance market, Warta had 11.5%, and Westa controlled 10.7% of the market. The remainder of the market had one notable private insurer Polisa (which controlled 0.8% of the market) and about 15 smaller companies.

(2). Westa appeared as the first private insurer to take a significant market share in the liberalised Polish insurance market. It grew rapidly on the basis of competitive pricing and aggressive advertising. Customers increasingly showed a preference for Westa due to its lower premiums and also in anticipation of better services than the nationalised insurers, which were considered to be somewhat inflexible. In effect, Westa broke the monopoly of State-owned insurers and introduced competition in the industry. Over a period of just four years, it recorded astonishing growth: the real growth rate of Westa was 176% in 1990 and 406.7% in 1991. To comply with the July 1990 insurance law in Poland which did not allow composite business to be carried out by an insurer, Westa split into two companies in February 1991-Westa (for non-life sector) and Westa life S.A. Together, the two sister companies controlled 11.16% of the market (1991-92), in terms of premium income.

(3). However, Westa's success was short-lived. In its desperate attempt to compete with the large and well established companies PZU and Warta, Westa cut down its premium rates to uneconomic levels. It advertised itself by declaring that "there was nothing that could not be insured and that the company was ready to insure anything that was of any value for the client." Thus, not only were Westa's premiums too low,

[3] The material of this section has been drawn from Booth and Stroinski (1994)

it also accepted risks which other insurers would have rejected. Allegations were made that risks were sometimes accepted by Westa without thorough inspections of what was actually being insured. Thus, inadequate pricing of several products (combined with bad design of certain products) and bad underwriting practices were the major problems with the functioning of Westa. Fraudulent claims by the insured customers of Westa was another source of problem. Over-expansion of operations, without sufficient capital, also added to the problems. Westa set up its branch offices and took on staff to run them over a very short span of time. Few of Westa's managers had previous experience in the field of insurance or adequate knowledge of the scientific disciplines underlying the business of insurance. As a result, the management of Westa ignored or bypassed the actuarial advice, and introduced products which were innovative, but sometimes not sound and often under priced. In the area of prudence of investments, Westa's performance was not better. It had given major loans to private companies, some of which defaulted. It did not try seriously to match its assets and liabilities, for instance, the reserves backing short-term policies were often devoted to buying real estate (a long-term investment).

As a result of all these problems, in 1992, Westa's reserves had become inadequate. While the State-owned insurer Warta (of the same share in the market as Westa) had reserves at over 100 percent of its premium income, Westa's reserves were only 20.8 percent. For a small insurance company beginning its operations mostly for short-term insurance, reserves at 20.8 percent of the premiums need not be inadequate. But Westa was no longer a small insurer. The defaulting investments and minimal cash assets of the company aggravated the financial problems of Westa.

The Ministry of Finance (the Polish insurance regulatory authority) withdrew Westa's license to write new business in October 1992; and the licnese of Westa life S.A. was withdrawn in January 1993. These were the first two cases of insolvency in the Polish insurance market in the five decades form early 1940s to early 1990s. At the time of insolvency, it was estimated that Westa needed roughly US $59 million and Westa Life S.A. needed about US $24 million to meet their projected liabilities not covered by assets.

The failure of Westa provides a typical example of insurance company failure in a liberal and competition environment.

(4). It must be noted that the loopholes in the Polish system of insurance regulation were certainly to be blamed for leaving enough scope for Westa to indulge in the various kinds of imprudent activities. The regulatory system, though required the new entrants to go through licensing procedures and provide business plans before establishment, "there was a clear intention to allow freedom in the operation of the business'. Also, insurance companies had the freedom to set their own premium rates and contract terms. The regulatory authorities expected the force of competition to influence rate setting and product innovation in such a very that consumers' changing needs could be met. However, the perspective of the Polish authorities about the implications of a liberal, competitive insurance industry proved to be misplaced.

Also, the Polish insurance law, which required the employment of actuaries by life insurance companies, did not provide actuaries with any significant power to dispute a company's decisions.

While the need for various types of regulatory measures related to solvency and market regulation of insurance companies has already been discussed, the case of Westa provides one additional insight as regards the appointed actuary system in insurance. As Booth and Stroinski (op. cit.) point out, regulation to strengthen the position of an actuary may help, in particular, when a 'named" actuary is responsible for ensuring that the company sets adequate premiums, etc. Also, the named actuary may be required to notify the regulatory authorities (combined possibly with the resignation from the concerned company) if the actuary felt that the company's decisions are irresponsible.

Chapter IV

A HISTORICAL ACCOUNT OF THE INDIAN INSURANCE INDUSTRY

The insurance industry in India prior to its nationalisation was characterised by dismal performance by the private insurance companies. The growing instances of market misconduct by the insurers as also the increasing number of insolvencies led to the nationalisation of life insurance business in 1956 and that of general insurance in 1972. The nationalisation of insurance industry, apart from protecting the interest of the policyholders, was also visualized to play a key role in channelising public savings for nation-building.

INSURANCE INDUSTRY IN INDIA IN THE PRE-NATIONALISATION ERA

Life insurance business, in its modern form, was first set up in India through a British company called the Oriental Life Insurance Company in 1818, followed by the Bombay Assurance Company in 1823 and the Madras Equitable Life Insurance Society in 1829. All these companies operated in India but did not insure the lives of Indians; they only insured the lives of Europeans living in India. Some of the companies which started later did provide insurance to Indians, but Indians had to pay an extra premium of 20 percent or more. The first company that had policies that could be bought by Indians at a 'fair value' was the Bombay Mutual Life Assurance Society started in 1871 (Sinha, 2003).

The first general insurance company, Triton Insurance Company Ltd., which was established in 1850, was owned and operated by the British. The first indigenous general insurance company was the Indian Mercantile Insurance Company Ltd. set up in Bombay in 1907.

By 1938, there were as many as 176 insurance companies (both life and non-life) operating in India. However, the industry was plagued by frauds, misappropriations,

mismanagement and arbitrary investments. This led to the passage of the Insurance Act of 1938, a comprehensive Act to regulate insurance business in India, which continues to be the fundamental legislation in respect of insurance regulation in India till date. Even after 1938, the dismal state of the insurance industry continued in India, and frauds and insolvencies remained as regular features of the private insurance companies.

Apart from the insolvencies and frauds, there was another characteristic feature of the insurance industry in the pre-nationalisation era. By 1956, there were 154 Indian insurance companies, 16 non-Indian insurance companies and 75 provident societies that were issuing life insurance policies. However, most of these companies were centred in the cities (especially around big cities like Bombay, Calcutta, Delhi and Madras). Thus, the penetration of the insurance industry in the rural areas was quite low.

NATIONALISATION OF INSURANCE INDUSTRY

The problems caused by the private insurers led to strong demands being raised for nationalisation of this industry. The life insurance industry was nationalised under the Life Insurance Corporation (LIC) Act of India in 1956. According to Sinha (op. cit.), the nationalisation of life insurance was driven by three major factors:

(1) insolvencies (as also frauds and mismanagement) of life insurance companies had become a big problem (at the time of take over of the private life insurance companies by LIC, in 1956, 25 companies were already insolvent and another 25 were on the verge of insolvency);

(2) it was perceived that private companies would not promote insurance in rural areas; and

(3) the government would be in a better position to channelise resources for saving and investment by taking over the business of life insurance.

However, nationalisation of non-life insurance came much later in 1972. For, efforts were made to maintain an open market for the general insurance industry by amending the Insurance Act of 1938 from time to time. But the earlier problem

persisted, misconduct by the private non-life insurers escalated beyond control. Thus, the general insurance industry was nationalised in 1972 by the passage of the General Insurance Business (Nationalisation) Act that year. This set up the General Insurance Corporation (GIC) as a holding company, and it had four subsidiaries: the National Insurance Company, the Oriental Insurance Company, the United India Insurance Company, and the New India Assurance Company.

Performance of LIC and GIC As Pubic Sector Monopolies

LIC has become successful, over the four and a half decades of its existence, in numerous ways. The successes of LIC can be enumerated as follows:

(1) LIC's market penetration in rural areas has grown substantially since its setting up in 1956—around 48 per cent of LIC's customers are from rural and semi-urban areas (this could be possible mainly because the charter of the LIC specifically set out the goal of serving rural areas of the country).

(2) LIC's claim-settlement ratio has been above 90 per cent, over the years. It should be noted here that the world average for claim settlement ratio is around 40 percent only, both in life and non-life insurance. Due to the high rate of claim settlement and other related factors, the level of satisfaction of the customers of LIC has been found to be very high in the past. A study by the market research agency MARG, done on behalf of the Malhotra committee, in the early 1990's found that roughly 92 percent of the policyholders of LIC expressed complete satisfaction with the quality of service.

(3) Between 1957 and 1998, the LIC was able to bring down the Renewal Expense Ratio from 15.89% to 6.09%, and the Overall Expenses Ration from 27.3% to 20.53%.

(4) One of the most commendable feats of LIC, over the period of its existence, has been its crucial role in channelising pubic savings for investments in development of infrastructure and other socially prioritised avenues in the country. Out of its huge investments to the tune of Rs. 1 lakh crore, LIC has invested 50 percent in the State and Central Government securities, 25 percent

in semi-Government and public sector, and roughly 10 percent in the cooperative sector. As of 1998, LIC's investment in housing, roads, rural electrification, municipal underground sewage construction, water supply, schools and small industrial estates, etc., exceeded Rs. 30,000 crore.

(5) LIC has turned out to be the biggest insurance company in the world in terms of number of policies sold and claims settled (Venu Gopal, 2004).

Table1: Some Relevant Data Regarding the Operations of the LIC

Item	As on 31/12/1957 (Immediately after nationalisation	As on 31/03/1998
1. No. of policies issued during the year (Rs lakh)	9.42	133.11
2. No. of policies in force (Rs lakh)	56.86	1100
3. Total premium income during the year (Rs. crore)	88.65	19,252.07
4.Total income including investment income during the year (Rs. crore)	107.15	30,732
5. Dividend to the Central Govt. (Rs. crore)	———	198.35
6. Overall expense ratio (%)	27.3	20.53
7. Renewal expense ratio (%)	15.89	6.09
8. Outstanding Claims Ratio (%)	38.5	3.19
9. Life fund as at the end of the year (Rs. crore)	410.4	1,05,832
10. Percentage of Rural Business	30.49	50

Source: Kerkar (1998)

The above table gives us a clear picture regarding the improvement in the performance of LIC over four decades from 1957 to 1998.

The performance of the GIC has been less impressive than that of the LIC. The GIC, which had been spread across 4 subsidiaries and some 2500 branches, had about 30 million individual and group insurance policies. The claim settlement ratio of GIC had been around 74 percent, which is much higher than the world average of around 40 percent. Also, the GIC had been investing 50 percent or more of its investible surpluses in mandated areas of development.

However, one of the criticisms has been that while setting up the GIC with its four subsidiaries, it was expected that the four public sector general insurance companies would compete with one another in the market, but this did not happen. Similarly, it was pointed out that the four companies did not set up their own investment portfolios either. Also, some observers have mentioned that a chunk of the GIC's branches have become unviable. The biggest criticism of the quality of service provided by LIC has been that there is delay in the settlement of claims.

The strongest criticism of the nationalised insurance industry has been made on the basis of India's very low levels of insurance penetration (premium as a % of GDP) and insurance density (premium per capita). The following table clearly shows that India's insurance penetration and density figures are considerably low in comparison to those of the developed countries. And, among the developing countries also, India does not get a relatively higher position. The advocates of insurance sector liberalisation held a view that the lack of competition in India's insurance sector hindered the growth of insurance business in the country and resulted in such low levels of insurance penetration and density.

Table 2: International Comparison of Insurance Penetration and Density

Country	Insurance Penetration (in %) 1999	Insurance Penetration (in %) 2000	Insurance Density (in US $) 1999	Insurance Density (in US $) 2000
U.K.	13.35	15.78	3244.3	3759.2
U.S.	8.55	8.76	2921.1	3152.1
France	8.52	9.40	2080.9	2051.1
Japan	11.17	10.92	3908.9	3973.3
Australia	9.82	9.41	2037.4	1859.3
Canada	6.49	6.56	1375.3	1516.8
Germany	6.52	6.54	1675.7	1491.4
South Korea	11.28	13.05	1022.8	1234.1
South Africa	16.54	16.86	490.9	472.1
Chile	3.78	4.07	163	175.8
Russia	2.13	2.42	26.8	41.8
Brazil	2.01	2.11	68.6	75.6
Mexico	1.68	1.72	84.6	101.2
Malaysia	3.88	3.72	140.4	150.9
India	**1.93**	**2.32**	**8.5**	**9.9**
PR China	1.63	1.79	13.3	15.2
Indonesia	1.42	1.18	9.5	8.6
Kenya	3.26	2.63	9.9	8.9
Nigeria	0.95	0.66	2.6	2

Note: Insurance Penetration = Premium as a % of GDP and Insurance Density = Premium Per Capita in US $.

Source: Swiss Re, SIGMA Volumes 9/2000 and 6/2001 (as referred to in IRDA Annual Report 2001-02).

However, the insurance density, which expresses the total volume of insurance premiums in a year in per capita terms, is bound to be low when, for a given level of insurance premiums, the population of a country is high. Thus, insurance penetration, which expresses the total volume of insurance premiums in a year as a percentage of the Gross Domestic Product of the country, is more plausible as a parameter for judging the performance of a country's insurance industry. But, there exists no strong argument to prove that the relationship between the national income of a country and

its total volume of insurance premiums is a linear one. If we consider two countries with different levels of per capita income and also with different levels of inequality in the distribution of the national income, the insurance penetration cannot be taken as an indicator to compare the performance of the insurance industries in the two countries, for the country with a higher level of per capita income combined with a lower level of disparity in the distribution of its income can be expected to have a higher level of insurance penetration when the structure and performance of the insurance industries in both the countries have been identical. Since India has had low levels of per capita income and a considerable degree of economic disparity among its population, the criticism of the erstwhile nationalised insurance industry on the basis of an international comparison of the insurance penetration and density figures does not seem acceptable.

LIBERALISATION OF THE INSURANCE INDUSTRY AND ESTABLISHMENT OF IRDA

1991 marked the beginning of liberalisation of Indian economy along the lines dictated by the International Monetary Fund (IMF). One of the major components of the IMF-style liberalisation was privatisation of and allowing foreign participation in the financial sector. So, the Government set up the Narasimham Committee for suggesting reforms in the banking sector and the Malhotra Committee (led by R.N. Malhotra, former Governor of RBI) to suggest reforms in the insurance sector. And, proving the fears of the critics of neo-liberal reform process true, both the Committees suggested increasing opening up—by allowing private participation and presence of foreign companies— of the respective sectors.

It was argued that opening up the insurance sector to domestic and foreign competition would make the insurance industry more efficient and ensure better conditions for consumers. It was argued that more products (in the form of new types of insurance policies) would be available and that premium rates would fall as new entrants would compete for market share, and that the existing nationalised insurance companies would be forced to deal with the threat and even reality of competition. More importantly, it was argued that, the availability of long-term funds to finance

infrastructure would benefit both from the additional premium income generated in the insurance sector and from the development of a market for long-term debt. Also, the opening up of the insurance sector was expected to augment the flow of finance to the corporate sector.

The policy makers also maintained the view that, keeping in mind the structural changes in other parts of the financial system of the economy, it was necessary to make the insurance industry more efficient and competitive (i.e., by allowing private and foreign participation). One argument given in favour of foreign participation in insurance business in India was that—the long years of LIC's and GIC's monopoly over this industry have resulted in an absolute lack of expertise and skills on the part of the Indian banks, financial institutions and other parties who were interested in entering this sector.

The Malhotra Committee Report, submitted to the Government in 1994, recommended, among other measures, that the insurance market should be opened to private sector competition, and ultimately, to foreign private sector competition. The purpose of setting up the Malhotra Committee, as stated by the Government, was to suggest a structure of the insurance industry in order to have a wide coverage of insurance services, to have a variety of insurance products with a high quality service, and to develop an effective instrument for mobilisation of financial resources for development. The major recommendations of the Malhotra Committee were:

(1) to allow Indian and foreign private companies to enter both life and general insurance as joint companies;

(2) to privatise the LIC and the GIC;

(3) to establish an Insurance Regulatory Authority; and

(4) to ensure that insurance companies pay special attention to the rural insurance business.

In the course of the next five years (i.e., after 1994), most of the recommendations of this committee were accepted, excepting, of course, the one about privatising the LIC and the GIC.

The Insurance Act, 1938 provides for the institution of the Controller of Insurance to act as a strong and powerful supervisory and regulatory authority with powers to

"direct, advise, caution, prohibit, investigate, inspect, prosecute, search, seize, fine, amalgamate, authorize, register and liquidate" insurance companies. After the nationalisation of life insurance industry in 1956 and the general insurance industry in 1972, the role of the Controller of Insurance had diminished in significance over a period of time. However, the Malhotra Committee, which recommended opening up the insurance sector to domestic and foreign private companies, held the view that there was need to set up an insurance regulatory apparatus even in the then prevailing set up of nationalised insurance sector and recommended the establishment of a strong and effective Insurance Regulatory Authority in the form of a statutory autonomous board. Accordingly, after uneven progress during the period from 1994 to 1999, the Government of India, along with opening up the insurance sector set up the Insurance Regulatory Authority (IRDA) as a statutory body having perpetual succession and a common seal through the IRDA Act, 1999.

Table 3: Milestones of Insurance Regulations in the 20th Century

Year	Significant Regulatory Event
1912	The Indian Life Insurance Company Act
1938	The Insurance Act
1956	Nationalisation of life insurance business in India
1972	Nationalisation of general insurance business in India
1993	Setting up of Malhotra Committee
1994	Recommendations of Malhotra Committee
1995	Setting up of Mukherjee Committee
1996	Setting up of (interim) Insurance Regulatory Authority (IRA); Recommendations of the IRA
1997	Mukherjee Committee Report submitted but not made public
1997	Government gives greater autonomy to LIC, GIC and its subsidiaries with regard to the restructuring of boards and flexibility in investment norms aimed at channelising funds to the infrastructure sector
1998	The cabinet decides to allow 40 % foreign equity in private insurance companies—26% to foreign company and 14% to NRIs, FII's and OCBs.
1999	The standing committee headed by Murali Deora decides that foreign equity in private insurance should be limited to 26%. The IRA bill is renamed IRDA Bill.
1999	Cabinet clears IRDA Bill
2000	President gives Assent to the IRDA Bill, 1999

Source: Sinha, Tapen (2003)

INDIAN INSURANCE INDUSTRY AT PRESENT

The following table presents an overview of the current state of India's insurance industry.

Table 4: Indian Insurance Industry in 2003

Size of Market, Life and Non-life	US $ 9.94 billion *
Total Global Insurance Premium	US $ 2422 billion
Geographical Restriction for new players	None. Players can operate all over the country
Equity Restriction in a new Indian insurance company	Foreign Promoter can hold up to 26% of the equity
Registration Restriction	Composite Registration not available
Type of Business	Number of Registered Companies
Life Insurance (Public Sector)	01
Life Insurance (Private Sector)	12
General Insurance (Public Sector)	04
General Insurance (Private Sector)	09
Reinsurance (Public Sector)	01
Reinsurance (Private Sector)	0
Anticipated Business of New (Private) Insurers in 2004-05 : Life	4 % to 5 % of total business
Anticipated Business of New (Private) Insurers in 2004-05 : Non-Life	10 % to 12 % of total business

Note: * According to FICCI Survey 2002

Source: IRDA, Second Annual Report 2001-02

The following table gives an idea of the growth of insurance industry over the last three years.

Table 5: Insurance Penetration and Insurance Density in India

Year	Insurance Penetration (Premium as % of GDP)			Insurance Density (Premium Per Capita in Rs)		
	Life	Non-life	Total	Life	Non-life	Total
1990-2000 (Annual Average)	1.41	0.49	1.90	274.72	96.09	370.80
2000-01	1.66	0.48	2.14	342.48	98.99	441.47
2001-02	2.18	0.55	2.73	483.07	122.42	605.49
2002-03	2.27	0.58	2.86	528.32	135.90	664.22

Source: IRDA, Third Annual Report 2002-03

In the first three years after liberalisation of the Indian insurance industry, the growth registered in the life insurance segment has been more than modest but that in the non-life segment has been very low. However, the opening up of the insurance market to domestic and foreign private players has resulted in a shrinking of the policy space available to the state in India vis-à-vis the insurance industry. When the new private insurers are competing for market share with the incumbent public sector insurers, with the expectation that the Government would make the environment in the insurance industry more and more conducive to their growth, promotion of public welfare through measures such as cross-subsidisation by the public sector insurers would become quite difficult in this liberalised environment. Moreover, the public sector insurance companies would be under increasing pressure to chase profits in every line of their business, relegating their crucial objective of reaching out to the public in a fair and even manner across the country.

Chapter V

REVIEW OF THE INSURANCE REGULATORY REGIME IN INDIA

On the basis of our discussion of insurance regulation in different countries, we may say that the strength of the regulatory regime (for insurance) in a country gets determined to a significant extent by the philosophy of the government as well as the regulators vis-à-vis the ability of a competitive insurance market to serve the public. Many developed countries who adhere to the views put forward in favour of free, competitive markets in general (i.e., for commodities other then insurance) deviate from such views when they deal with an insurance market. Due to the peculiarities of the insurance contract and of a system of voluntary private insurance, there exists a strong case in theory in favour of strictly regulating an insurance industry. In view of a number of factors relating to the business of insurance, such as-

- the fact that insurance coverage is highly beneficial for every individual if available at a fair price
- in a voluntary market for private insurance the tendency of the firms (in pursuit of containing adverse selection and boosting their profits) is towards breaking down the larger pool of potential customers in search of smaller, less-risky and more profitable pools
- incentives for insurance companies to use their investible surpluses in risky investment avenues and
- the losses caused to the insureds in case of insolvencies of insurers—

there should be no doubt about the need for thoroughly regulating a competitive insurance industry comprising private insurance companies with or without the simultaneous participation of public sector insurance companies. However, in practice, the philosophies of the different countries as regards scope and stringency of regulatory measures seem to have been influenced considerably by the experiences of the countries with private, competitive insurance markets.

In case of India, the philosophy of the governments at centre during the last decade as well as that of the regulators of insurance (after the setting up of IRDA in 2000) regarding the business of insurance seems to have been that —a free, competitive insurance market generally leads to lower premium rates, better risk coverage and better products to deal with the growing needs of the insurance buying public; however, there has to be some degree of intervention in that free market to ensure that there is 'fair' competition and not 'cut-throat' competition that can lead to insolvencies of insurers. While the second part of this philosophy is correct, the first part is fallacious. In case of insurance industry specifically, the fallacy in understanding could have been influenced significantly by the experience of the country with nationalised insurance industry (for more than four decades in case of life insurance and close to three decades in case of non-life insurance) which did not see either insolvency of insurers or fragmentation of the market or unfair practices being adopted by the insurers. The advent of neo-liberalism also can be expected to have shaped such an understanding. According to Ericson et al (2000), the five basic points about the neo-liberal discourse on risk are—"minimal state; market fundamentalism; emphasis not only on risk management but also on risk taking (i.e., as participants in fast-moving and fluctuating markets, people must become educated, knowledgeable and reflexive risk-takers who are adaptable to changes); emphasis on individual responsibility (i.e., each individual is to be an informed, self-sufficient consumer of markets for different commodities); and, within a regime of responsible risk taking, all differences, and the inequalities that result from them, are seen as a matter of choice. Further, when conceived as a choice, the inequality among individuals is also seen as inevitable."

The understanding of Indian policymakers and regulators, who have been instrumental in building up the current regime of insurance regulation, does not reflect any gross negligence of either the inequality in Indian society or the experiences of different countries with competitive insurance markets; but the tilt is clearly in favour of free, competitive markets for insurance. Accordingly, while the current system of regulation under IRDA covers many important aspects of the business of insurance as well as the specific needs in case of India, many of the regulatory measures are weak and the approach is towards a more flexible regime in future.

LEGISLATIVE FRAMEWORK FOR INSURANCE REGULATION [4]

The principal legislation regulating the business of insurance in India is the Insurance Act of 1938. Some other existing legislations affecting the insurance business are the Life Insurance Corporation (LIC) Act of 1956, the Marine Insurance Act of 1963, the General Insurance Business (Nationalisation) Act of 1972, the Insurance Regulatory and Development Authority (IRDA) Act of 1999, the Insurance Amendment Act of 2002, and the General Insurance Business (Nationalisation) Amendment Act of 2002. Apart from these, the provisions of the Indian Contract Act, 1872 are applicable to the insurance contracts (both life and non-life), and the provision of the Companies Act, 1956 are applicable to the companies carrying on insurance business in India.

The subordinate legislation that have contributed towards building up the currrent legal framework for insurance regulation are the Insurance Rules of 1939, the Ombudsman Rules of 1998 framed by the Central Government, and the regulations made by the IRDA. We shall focus on the IRDA Act, 1999 and the regulations made by the IRDA, which are the two main building blocks of the current regulatory structure.

The IRDA Act, 1999

This Act provided for the establishment of IRDA to "protect the interests of holders of insurance policies, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto", and made relevant amendments (for opening up the insurance sector as well as setting up the regulatory structure) to the Insurance Act of 1938, the Life Insurance Corporation Act of 1956 and the General Insurance Business Act of 1956 and the General Insurance Business (Nationalisaton) Act of 1972. This Act provides for the composition of the IRDA; terms and conditions of the chairperson and member including their tenure and removal; duties, powers and functions of the IRDA including regulation making power and delegation of powers; establishment of Insurance Advisory Committee; IRDA Fund; and powers of the Central Government to make rules, to issue directions to IRDA and to supersede them, if it is necessary; and other miscellaneous provisions.

[4] The material for this section has been drawn from the Consultation Paper of the Law Commission of India(2003) and from the Annual Reports of IRDA

Three schedules were appended to this IRDA Act, 1999. The First Schedule appended listed out several amendments to the Insurance Act of 1938, the Second Schedule ceased the exclusive privilege of LIC to carry on life insurance business in India, and the Third Schedule appended to the IRDA Act, 1999 ceased the exclusive privilege of the GIC and its four subsidiaries in relation to the conduct of general insurance business in India.

The amendments made to the Insurance Act of 1938 (through the First Schedule) prohibited insurers other than Indian insurance companies to carry on insurance business in India and investment of funds of policyholders outside India. These amendments also provided for—

(i) requirements of paid-up equity capital for both insurers and reinsurers;

(ii) manner of divesting of excess share holding by promoters;

(iii) manner and conditions of investment;

(iv) maintenance of required solvency margin at all times by the insurers;

(v) issue of license to insurance agents, intermediaries or insurance intermediaries and surveyors by IRDA as also the suspension and cancellation of these licenses;

(vi) obligations of insurers to compulsorily undertake specified percentage of insurance business in rural and social sector (which refers to unorganised sector workers, and economically vulnerable or backward classes);

(vii) enhanced penalties for contravention of and failure to comply with the provisions of the Insurance Act of 1938, offences by insurance companies; and

(viii) powers of the IRDA to make regulations as required by the Act.

Duties, Powers and Functions of IRDA:

As per the IRDA Act, 1999, the IRDA has the duty to "regulate, promote and ensure orderly growth of the insurance business and reinsurance business".

The powers and functions of IRDA include:

(a) to issue to the applicant a certificate of registration, renew, modify, withdraw, suspend or cancel such registration;

(b) protection of the interests of the policyholders in matters concerning assigning of policy, nomination by policyholders, insurable interest, settlement of insurance claim, surrender value of policy, and other terms and conditions of contracts of insurance;

(c) specifying requisite qualifications, code of conduct and practical training for intermediary or insurance intermediaries and agents;

(d) specifying the code of conduct for surveyors and loss assessors;

(e) promoting efficiency in the conduct of insurance business;

(f) promoting and regulating professional organisatons connected with the insurance and reinsurance business;

(g) levying fees and other charges for carrying out the purposes of the IRDA Act, 1999;

(h) calling for information from the insurers as well as intermediaries;

(i) undertaking inspection/conducting enquiries and investigations (including audit) of the insurers and intermediaries;

(j) control and regulation of the rates, advantages, terms and conditions that may be offered by insurers in respect of general insurance business, which are not controlled and regulated by the Tariff Advisory Committee (TAC);

(k) specifying the form and manner in which books of account shall be maintained and statement of account shall be rendered by insurers and insurance intermediaries;

(l) regulating investment of funds by insurance companies;

(m) regulating maintenance of margin of solvency;

(n) adjudication of disputes between insurers and intermediaries or insurance intermediaries;

(o) supervising the functioning of the Tariff Advisory Committee;

(p) specifying the percentage of premium income of the insurer to finance schemes for promoting and regulating professional □rganizations referred to above in (f);

(q) specifying the percentage of life insurance business and general insurance business to be undertaken by the insurer in the rural or social sector; and

(r) exercising such other powers as may be prescribed.

The crucial importance of the duties, power and function of IRDA, as provided for in the IRDA Act, 1999, is that these provisions set out the objective of IRDA as well as the different areas relating to the business of insurance in India in which IRDA can intervene through its regulations. A critical assessment of these legal provisions of the IRDA Act, 1999 is presented later in this chapter.

In pursuance of its duties, powers and functions under the IRDA Act 1999, IRDA has framed 27 sets of regulations, during the first three years from April 2000, on various aspects of the insurance business in India. These regulations form the most important part of the insurance regulatory regime in the country. A brief description of some of the important regulations is presented later in this chapter.

Some of the other relevant provisions made under the IRDA Act, 1999 are as given below.

Insurance Advisory Committee:

The IRDA Act, 1999 provides for the constitution of an Insurance Advisory Committee, which can consist of a maximum of twenty-five members excluding the chairperson and members of IRDA (who are to be ex officio members of this Committee); and the members of this Committee should represent the interests of commerce, industry, transport, agriculture, consumer fora, surveyors, agents, intermediaries, organisations engaged in safety and loss prevention, research bodies and employees' association in the insurance sector. The IRDA is required to consult with this Insurance Advisory Committee while making regulations.

Participation of Parliament in the Making of Regulations:

The IRDA Act, 1999 requires every rule and every regulation made by IRDA to be cleared by both the Houses of Parliament before it can come into force. Any decision about modification or annulment of the rule/regulation, to which both Houses agree, will have to be obeyed.

Powers of the Central Government:

IRDA is required to obey the directions given by the Central Government on questions of policy; and the decision of the Central Government regarding whether a question is one of policy or not shall be final. The Central Government, by notification and specifying reasons in that notification, can supersede IRDA for period of up to six months; and, during this period of supersession, the Central Government shall have to appoint a person as Controller of Insurance. Also, the Central Government may make rules for carrying out the provisions of the IRDA Act, 1999.

Legislative Developments After 1999

Initially, until the Insurance Amendment Act 2002 was passed, insurers were allowed to operate as joint stock companies only. However, the Reserve Bank of India's Advisory Group on Insurance Regulation recommended that, for spreading insurance business in rural areas, the role of co-operatives should not be ruled out (RBI, 2000). Later, the Insurance Amendment Act, 2002 permitted insurance co-operative societies, registered under the Co-operative Societies Act, 1912 or Multi-State Co-

operative Societies Act, 1984 or under any state law relating to co-operative society, to carry on any class of insurance business. However, it is important to note here that, IRDA has been empowered to exempt an insurance co-operative society from the application of any of the provisions of the Insurance Act, 1938 or application of its provisions with exceptions, modifications or adaptations. The Insurance Amendment Act, 2002 also permitted for a portion of the premium received from the insured to be paid as remuneration to an "insurance intermediary", including insurance brokers and consultants. This amendment (to the Insurance Act 1983) introduced the insurance brokerage business in India. The rationale for this provision has been that in a country like India, with a huge population and a vast geographic area, such a practice will help expand the business of insurance in the country. The General Insurance Business (Nationalisation) Amendment Act, 2002 ceased the right of GIC to carry on general insurance business in India and its authority to control the four public sector general insurance companies, and this Act made the GIC the only reinsurer to carry on exclusively reinsurance business in India. As regards the four public sector general insurance companies, the Central Government was authorised to discharge the functions previously performed by the GIC.

Revision of the Insurance Act, 1938 the IRDA Act, 1999:

The IRDA made a reference to the Law Commission of India for giving recommendations on—merging the provisions of the IRDA Act with those of the Insurance Act in order to avoid multiplicity of legislations; amending and updating provisions of the Insurance Act to meet the current needs of the insurance industry; bringing consistency between the various provisions placed in different sections of the Insurance Act; and recasting certain sections so as to remove ambiguity and make them specific and clear. The law commission has issued a consultation paper on this matter suggesting numerous changes and modifications. This consultation paper of the Law Commission, among other things, has focused on the need for a full fledged grievance redressal mechanism and on raising the limits on the fines and penalties to be levied under the Insurance Act, in order to ensure adequate in-built deterrence in the regulatory mechanism.

Tariff Advisory Committee

The Tariff Advisory Committee (TAC) was established in 1969 (by an amendment to the Insurance Act, 1938). The purpose of the TAC was to control and regulate the rates, advantages, and terms and conditions that may be offered by the general insurers in India. As of now, one of the functions of IRDA (as per the IRDA Act 1999),is to supervise the functioning of the TAC, and the chairman of IRDA is the ex officio chairman of TAC.

The TAC is presently administering the tariff in respect of certain specified segments of the general insurance business, as shown in the table below.

FIRE	All India Fire, Petrochemical, Industrial All Risks, Consequential Loss (Fire) Tarifff
MARINE	Marine Hull, Fishing Vessels, Tea Tariff
ENGINEERING	Contractor's All Risk (CAR), contractor's Plant and Machinery (CPM), Electronics Equipments Insurance, Machinery Breakdown, civil Engg. Completed Risks (CECR), Storage cum Erection, Loss of Profit, Boiler and Pressure Vessels, and Deterioration of Stocks (Potato) Tariff.
MOTOR	All India Motor Tariff
MISCELLANEOUS	Workmen Compensation

Source: IRDA Annual Report 2000-2001

Note: Large risks where the threshold limit or Probable Loss Limit is Rs.1054 crore or above, at any one location or where sum insured at any one location is Rs.10,000 crore or above have been de-tariffed. As a result, the rates for these mega risks will now be governed by the rates charged for reinsurance to the Indian insurers by the international reinsurers (IRDA, Annual Report 2000-2001)

In case of all other segments of general insurance business, which do not come under the control of TAC, the rates, advantages, terms and conditions are determined by the insurers themselves on the basis of their own pricing and risk underwriting policies. These non-tariff products in general insurance have to be filed by the insurers with IRDA, under the 'file and use' procedure. For the financial year 2002-03, non-tariff business constituted about 25 percent of gross direct premium underwritten in the non-life/general insurance segment in India (IRDA Annual Report 2002-03).

The rationale behind shrinking the control of TAC over the general insurance business and deregulating rates, as put forward by the Malhotra Committee (1994) and IRDA (Third Annual Report, 2002-03) can be summarised as:

(a) de-tariffing of non-life insurance business is a possible remedy to arrest the breach of tariff by the insurers (IRDA, Annual Report 2002-03);

(b) a progressive reduction of the area (or lines of business) under tariff would promote competition and improve underwriting skills of the non-life insurers (Malhotra Committee); and

(c) tariffs, per se, discourage adaptability to the changing needs of the insurance consumers and deprive the market of innovation (IRDA, Annual Report 2002-03).

This rationale for deregulation of rates (in the non-life insurance sector) has driven the following developments relating to de-tariffing of the non-life insurance business in India:

(a) The Justice Rangarajan Committee set up in October, 2002 (on motor insurance) has recommended de-tariffing of the own damage business of the motor insurance portfolio, under a competitive premium setting model, with effect from April, 2005.

(b) Motor insurance, constituting about one-third of the total non-life insurance business in India, continues to be a loss-making portfolio, and hence, new private insurers are unwilling to insure commercial

vehicles (e.g., truck, tankers, taxis) and old vehicles. The private insurers have also argued that the TAC should put a cap on third party liability (insurance claims). In response to this, the TAC had appointed a Committee under the Chairmanship of a past IRDA member (the H. Ansari Committee), which among the other measures suggested for a general enhancement of the motor insurance premium structure. Subsequently, the IRDA felt that the general enhancement of the premium structure suggested by the committee, in respect of certain segments (such as own damage portion of personal vehicles) was steep and the increases were toned down (IRDA, Annual Report 2001-2002). However, an increased premium structure for motor insurance was implemented in July 2002. Following this development, some people filed writ petitions in a number of High Courts (Calcutta, Madras, and Kerala) challenging the rate increases, and more specifically the manner in which the insurers had implemented the higher premiums as well as denied the opportunity for covering third party liability. It must be noted here that third party liability insurance is mandatory for all vehicles plying in India.

(c) The expert committee set up by IRDA, under the chairmanship of A.C. Mukherjee, has recommended that immediate steps be taken to de-tariff the entire general/non-life insurance market by April, 2006; and has advocated the adoption of pure risk premium basis tariff for a period of two years after April, 2006. This process of opening up the market to free and competitive pricing, according to IRDA (Third Annual Report 2002-2003), "would be accompanied by adoption of prudent underwriting among the consumers on the likely benefits of de-tariffing which would percolate down to them."

Apart from the legal provisions relating to IRDA, its powers and functions, and the role of the Tariff Advisory Committee, the institution of Insurance Ombudsman is another imported constituent of the legislative framework for insurance regulation in India.

The institution of Insurance Ombudsman, was created (by a Central Government Notification in 1998) for the purpose of quick disposal of the grievances of the insured customers and to mitigate their problems involved in redressal of those grievances by the insurers. From the point of view protection of interest of policyholders, the institution of Insurance Ombudsman is of crucial importance in India's insurance regulatory regime. A committee comprising the chairman of IRDA, the Chairman of LIC, the Chairman of GIC, and a representative of the Central Government takes the decision regarding appointment of the Ombudsmen. At present there are twelve Ombudsmen across the country with different geographical areas alloted to them as their jurisdictions. The Insurance Ombudsman has been empowered to receive and consider complaints from any person who has grievances against an insurer in personal lines of insurance. The Ombudsman can perform both the function of conciliation as well as that of award making. The Ombudsman is required to make an award (when he decides in favour of the insured) within a period of three months from the receipt of the complaint, and the awards are binding upon the insurance companies. If the consumer/policyholder is not satisfied with the award of the Ombudsman he can approach other institutions like Consumer Forums and Courts of Law. Also, the insurance companies are required to honour the awards passed by an Ombudsman within three months. However, the Ombudsman's powers are restricted to insurance contracts not exceeding Rs. 20 lakhs.

REGULATIONS LAID DOWN BY IRDA[5]

As we have discussed above, the Indian regulatory authority for insurance, IRDA, is required to make regulations to carry out the purpose of the IRDA Act, and the regulations have to be consistent with the provisions of this Act. Some of the important regulations laid down by IRDA are given below.

[5] The material for this section has been drawn from the Annual Reports of IRDA and various Notifications brought out by IRDA relating to the Regulations.

Protection of the Interest of the Policyholders

Towards achieving this objective, IRDA has taken the following steps:

(i) The insurers are required to maintain solvency margins so that they are in a position to meet their obligations to the policyholders.

(ii) Clearly disclosing the benefits, terms and conditions under the policy is obligatory for the insurers.

(iii) Benchmarks on customer services have been set. The concepts of free look (under which, a potential customer is given some additional time to reconsider his purchase decision even after he has agreed to purchase an insurance policy once) and interest to be paid on delayed settlement of claims have been introduced.

(iv) All insurance companies are required to have a consumers' representative on their Board as member.

(v) A consumer's representative has been nominated on the Insurance Advisory Committee.

(vi) IRDA pursues complaints received from policyholders with the concerned insurers.

(vii) 'File and use' system has been introduced for all insurance products, which are not controlled by TAC, under which IRDA checks that the interests of the policyholders are protected in the filed insurance contract.

(viii) A code of conduct has been introduced for insurance agents and intermediaries, including brokers.

Maintenance of Solvency Margins of Insurers

(i) The IRDA (Assets, Liabilities, and solvency Margins of Insurers) Regulations, 2000 stipulate that all life insurers should maintain a minimum solvency margin (which is the excess of value of assets over liabilities of either Rs 50 crore or a sum equivalent based on the prescribed formula given in IRDA (Actuarial Report and Abstracts) Regulations 2000, whichever is the highest. In case of general insurers, the regulations stipulate that the minimum solvency margin should be

either Rs 50 crore or a sum equivalent to '20% of the net premiums (gross premiums less of reinsurance payments) 30% of net incurred claims (average for three preceding years), whichever is the larger of the two'.

(ii) There is a 50% upper limit (or ceiling) on the amount of reinsurance that can be used to calculate net premiums for calculations of the solvency margin.

(iii) The lowver bound on solvency margin (which is Rs 50 crore for any primary/direct insurer) is Rs 100 crore for a reinsurer.

(iv) Available Solvency Margin of an insurer divided by the Required Solvency Margin (which is calculated according to the formula prescribed in the regulations) of the insurer gives a ratio, called the Solvency Ratio. The regulations regarding the registration of new insurers requires them to maintain a solvency ratio which is 1.5 times the normal solvency ratio requirement.

Monitoring of Investments of the Insurers

(i) The IRDA Act, 1999 prohibits the investment of funds of the insurance companies outside India.

(ii) IRDA has mandated the pattern of investments to be followed by the insurance companies, specifying the minimum percentage of investments to be made in government securities, in the infrastructure and social sector, and as loans to state Governments. Other than these avenues, the insurance companies can make certain types of 'approved investments', which may be governed by certain Exposure/Prudential Norms.

(iii) IRDA has made it mandatory for all insurers to submit an investment policy before the start of an accounting year.

Monitoring of Reinsurance

(i) The reinsurance programme of each insurer, in the non-life segment, is required to be guided by the basic tenets of maximising retention within India, developing adequate capacity and securing the best possible protection for the reinsurance costs incurred.

(ii) In case of reinsurance by life insurers, IRDA requires them to draw up a programme of reinsurance in respect of lives covered by each insurer and get it certified by its appointed actuary. Further, such a certified profile of the reinsurance programme giving the names of all reinsurers involved should be filed with IRDA at least forty five days before the commencement of each financial year.

(iii) The GIC has been notified as the Indian reinsurer. As regards the non-life insurers, IRDA requires them to compulsorily cede 20% of their gross premiums to the Indian reinsurer, subject to limits in fire, engineering and energy business.

Regulation of Accounting and Actuarial Standards

(i) IRDA has issued regulations concerning preparation of financial statements and Auditor's Report to be prepared by the insurance companies, which broadly fall within the purview of the Accounting Standards (AS) issued by the Institute of Chartered Accountants of India.

(ii) The system of Appointed Actuary has been introduced for all insurers operating in India. No insurer can transact life insurance business in India without an Appointed Actuary, working as a full-time employee (with the life insurer). In case of non-life insurers, a consultant actuary can be appointed, and not necessarily one who is a full-time employee. This relaxation has made due to the shortage of actuaries for non-life insurance in India.

Entry of Brokers into the Insurance Market

(i) The Insurance Amendment Act 2002 has permitted brokerage to paid from the premiums in the insurance business in India. Following this legislative changer, IRDA has been taking steps for expanding the number of intermediaries in the insurance industry, including insurance brokers and consultants. As of 2003, there were roughly 5 lakh insurance intermediaries in the country, out of which roughly 2 lakh were for the rural areas.

(ii) IRDA has laid down codes of conduct and fair market conduct rules for all types of intermediaries.

Co-operative Societies for Carrying Out Insurance Business

The Insurance Amendment Act 2002 also allowed co-operative societies to be formed specifically for carrying out insurance business. According to IRDA regulations, such co-operatives will be subject to the same paid-up capital requirement, and solvency requirements as the insurance companies.

Restrictions in Registration of New Insurers

(i) No insurer can get a license to carry out composite business, i.e., both life and non-life insurance business, in India.

(ii) A foreign insurer can enter the Indian market only through a joint venture with an Indian promoter. Foreign promoter can hold up to 26% of the equity (however, the Union Budged of July 2004 has proposed to raise this equity cap to 49%) in a new Indian insurance company.

(iii) There is no geographical restriction for the new players. They can operate all over the country.

Rural and Social Sector Obligations

(i) Under the IRDA's rural sector obligations for the insurers; 'rural sector' means any place which as per the latest census has a population of not more than 5000, a population density of not more than 400 per square km, and

where at least 75 percent of the male working population is engaged in agriculture. For all the new entrants, the rural sector obligations are as given below:

(a) in respect of a life insurer—

(i) 5 percent of total policies written direct in the first financial year

(ii) 7 percent of total policies written direct in the second financial year.

(iii) 10 percent in the third financial year.

(iv) 12 percent in the fourth financial year and

(v) 15 percent in the fifth financial year.

(b) In respect of general insurer—

(i) 2 percent of total gross premium income written direct in the first financial year.

(ii) 3 percent of total gross premium income written direct in the second financial year and

(iii) 5 percent thereafter

(ii) Social sector, as per the regulation of IRDA, includes unorganised sector, economically vulnerable or backward classes (people living below the poverty line) and people with disability, in both rural and urban areas. The social sector obligations, in respect of all insurers, are—

(I) 5000 lives in the first financial year

(II) 7500 lives in the second financial year

(III) 10,000 lives in the third financial year

(IV) 15,000 lives in the fourth financial year

(V) 20,000 lives in the fifth year.

APPRAISAL OF THE LEGISLATIVE FRAMEWORK AND REGULATIONS

(1). Many of the loopholes in the regulatory regime for insurance in India seem to be rooted in the dual responsibility given to the regulatory authority, i.e., of protecting the interests of the insurance policyholders and ensuring growth of insurance business in the country. The Insurance Regulatory and Development Authority (IRDA) is trying to put in place a liberal and competitive environment in the insurance industry so as to help the new, private insurance companies register appreciable growth and compete with the incumbent public sector insurers, which is also expected to augment the flow of long-term financial resources not only to the infrastructure and social sector activities but also towards the corporate sector. Since our discussion of the various issues relating to regulation of insurance as well as our survey of the regulatory regimes in different countries clearly suggest that the fundamental objective of insurance regulation is to protect the consumers in the insurance market, we shall assess the regulatory regime is India on the basis of its ability and intent to perform this fundamental duty of protecting the interests of the insurance buying public.

We observe that the protection of consumers does not find any explicit mention in the 'duty' of IRDA, as provided for by the IRDA Act, 1999. On the other hand, IRDA has been assigned the duty to not only regulate but also promote and ensure orderly growth of the insurance and reinsurance business in the country. Again, the IRDA Act mentions promoting efficiency in the conduct of insurance business as one of the functions of IRDA. If this efficiency is taken to mean efficiency of an insurance firm in the sense it is used in conventional economic theory, then IRDA will not be able to prevent the insurers from discriminating against those sections of the population who are more vulnerable to losses.

(2). While in the United States, every State has been given the authority and responsibility to regulate insurance business within its geographical boundaries; in the Indian case, the authority to regulate insurance is centralized with IRDA and the central government.

(3). The IRDA Act clearly mentions that, in questions of policy, IRDA is bound to obey the decision of the Central Government. This restriction might constrain the

ability of IRDA to take decisions on key issues that might have a significant bearing on the interests of consumers in the insurance market. Also, Sinha (2003) observes that the Chinese Insurance Regulatory Commission has the power to make laws so as to fulfil its responsibilities, but IRDA is merely a law-implementing body. IRDA is bound by the areas of regulation that have been provided for in the IRDA Act.

(4). As regards the legal provision for setting up co-operatives for exclusively carrying on insurance business, IRDA observed that "by nature of their being engaged in the activity of disbursing credit and being closer to the rural markets, co-operatives are expected to help in the penetration of insurance cover to rural areas" (Annual Report, 2001,02). However, IRDA's regulations for such co-operatives requires them to fulfil the same conditions of capital and solvency as the insurance companies. While the intention of IRDA is to protect the insureds from insolvency of co-operatives it ignores the fact that insurance co-operatives of very small size targeting certain sections of the population in the rural areas can be highly beneficial for people in the rural areas, but such co-operatives will never come into existence under the current regulations. And, it should be noted here that the Insurance Amendment Act 2002 has given authority to IRDA to exempt the co-operatives from any of its regulations.

(5). As Pant (1999) had pointed out in case of the IRDA Bill, which was later enacted, if the intention of the legislation is to enable IRDA to prescribe marketing of insurance products amongst under-served segments in rural areas in a concessional and affordable manner, then this needs to be clearly spelt out. Similarly, in case of social sector (which refers to unorganised sector, informal sector, people living below the poverty line and people with disability—according to the regulations laid down by (IRDA), if the intention of the legislation is to enable IRDA to prescribe minimum insurance coverage of deprived sections of the population by the insurance companies at prices affordable to such sections, it should have been specifically mentioned in the IRDA Act. These loopholes in the IRDA Act have been carried over fully into the regulations of IRDA regarding rural and social sector obligations of the new insurance companies.

By specifying merely the percentage of business to be covered in the rural areas by the insurers, the problem of growing disparity between the economic abilities of different regions of the country has been grossly ignored. Also, the number of lives to be covered by the insurance companies so as to fulfil their social sector obligations is grossly inadequate, keeping in mind the facts that social security system in India is non-existent and a sizable proportion of the population is economically vulnerable.

(6). In the area of structural regulation, the Indian regulatory regime has been made rather flexible and banks have been allowed to enter the insurance sector through subsidiaries. The banks need prior approval of the banking regulator, i.e., the RBI, to be able to do so. As we had observed earlier in this study, the overall approach in India towards the regulation of the financial services sector is the pillars approach, under which there are three separate regulators for the banking, insurance and securities markets. Also, many of the new insurance companies are joint ventures between foreign insurers and non-financial corporations from India. Therefore, the adverse consequences of weak structural regulation, which we have discussed earlier, cannot be ruled out in case of Indian insurance industry in future.

(7). In the area of solvency regulation, the approach taken by IRDA resembles that of the E.U. which we had called as the traditional approach to solvency regulation. As long as the new insurance companies have a relatively small volume of business, the solvency requirements set by IRDA can be expected to serve well towards preventing insolvencies. However, in future, as the new insurers write higher volumes of business, the risk-based-capital approach (as practices in the U.S.) to solvency regulation could prove to be better.

(8). The introduction of the Appointed Actuary system is one of the positive features India's insurance regulation regime. This measure can be expected to act as a safeguard against bad underwriting practices being adopted by the insurers and serve towards preventing insolvency of insurers.

(9). However, there is no legislation in India that provides for underwriting restrictions on insurers (Mahal, 2002). This is a major drawback in the Indian regulatory regime, since many countries (e.g., China, Japan) strictly regulate the

underwriting practices of insurance companies. As a result of the flexibility given to the insurers in risk underwriting, they can be expected to indulge heavily in discrimination among the potential customers resulting in fragmentation of the market for insurance in India. Given the relatively high levels of socio-economic inequality among the people of this country, the sections of the population who are more vulnerable to losses can be expected to belong to the economically poorer strata. In such a scenario, if the private insurers are not restricted from discriminating against less profitable potential customers, a sizable chunk of the country's population will get excluded from the voluntary market for private insurance. Given the non-existent social security system in India, the consequences of such a development could be quite harmful for people in general.

(10). The approach of Indian regulators towards rate regulation in insurance seems to be the weakest part in the Indian regime. Following the recommendations of the Malhotra Committee, a substantial portion of the general insurance business in India has already been de-tariffed. And, the developments vis-à-vis the Tariff Advisory Committee (discussed earlier in this chapter) are clearly towards de-tariffing a major part of the general insurance business. The consequences of such deregulation can be quite adverse for the consumers. The happenings in the motor insurance segment are a pre-cursor of the things to come in many lines of non-life insurance business, if IRDA moves the insurance industry towards an environment of greater deregulation of rates. In fact, motor insurance is a loss-making portfolio in the insurance market of almost every country, and in particular the third party liability portion causes losses. However, even in the U.S., many states have made it mandatory for the non-life insurers to provide third party liability coverage. The IRDA should take into account these facts before giving greater flexibility to he private insurers in India.

(11). IRDA could also take steps towards establishing a Guarantee Fund in India for the purpose of providing coverage against the insolvency of an insurer. As we had noted earlier, such a Guarantee Fund can be expected to have more benefits in terms of protecting the interests of the insurance policyholders than moral hazard costs in case of a country like India.

(12). As regards market regulation, the approach of IRDA is towards establishing self-regulation by the insurance industry. IRDA, in its Annual Reports, has explicitly stated that it expects the life and non-life insurance councils, which consist of the Chief Executive Officers of all the insurance companies in the respective sectors, to take up the responsibility of ensuring that the insurers do not indulge in unfair market conduct. However, IRDA's primary objective should be to protect the consumers, which can be better ensured if market regulation is implemented by government authorities.

(13). The institution of Insurance Ombudsman is of crucial importance for redressal of the grievances of consumers vis-à-vis insurance companies. Therefore, IRDA should try to strengthen this institution, in terms of the scope of the Ombudsmen and their powers to give awards, and it should try to make these Ombudsmen easily accessible to the people all over the country.

(14). IRDA should have the vision to serve and protect all potential buyers of insurance in the country, not just those who are existing customers of the insurance companies.

CONCLUSION

This study took up several important questions relating to regulation of insurance industry and tried to build up an analytical framework, based on a discussion of the theoretical arguments and a survey of the developments across different countries, to assess the insurance regulatory regime that has been put in place in India through the IRDA. The main conclusions of the discussions presented are summarised below.

A system of insurance is needed mainly because of two fundamental reasons. The first is that individuals, firms, and the society as a whole, face different kinds of risks, which, if realised, can cause significant losses. And, both individuals as well as firms are incapable of managing many of those risks as competently as the system of insurance can. The second fundamental reason has been traced in the primary functions performed by insurance, which are: (1) it transfers risks from an individual or a firm to an entity which is better able to cope with it and (2) it leads to a sharing of losses, on some equitable basis, by a large number of people.

It has become a common practice among the mainstream economists to argue for a competitive insurance industry, characterised by the presence of a sizable number of private insurance companies. However, in practice, competitive insurance markets, comprising private insurers, lead to welfare losses on several grounds. This is evident from the extensive regulation of insurance industry which has been adopted by many countries, most notably, the United States. The argument made in favour of a liberal competitive insurance industry, that such an environment would generally lead to lower premium rates, better risk coverage and better claims service, is misleading. In a liberal competitive insurance market, premiums can come down, coverage may expand and claims service can improve, but only for a select group of people facing lesser exposure to risks, not for the entire group of people taking part in the insurance market. One of the

ironies of private insurance industry is that, while it is supposed to pool risks, in practice it tends to unpool them, breaking down the larger pool of potential insured in search of smaller, less risky pools, which are more advantageous for some, while excluding others. Premiums within these smaller pools can be kept lower and claims service can be higher, but only for those fortunate enough to be included.

Besides this fundamental problem (from the point of view of the insurance buying public in a society) with a system of private voluntary market for insurance, there exist several other reasons for government intervention in the insurance market. But that intervention could be in different forms, such as, compulsory public provision of insurance, operating public sector insurance companies in the market for private insurance, or state regulation of the insurance industry. Of all these, state regulation of insurance industry is the most prevalent form of government intervention in many countries at present. There seems to be a consensus among economists regarding the need for state regulation of insurance, with even those adhering to the market failure view of government intervention (i.e., accepting any form of government intervention only if a private voluntary market fails and the government is capable of rectifying such failures) not questioning it. As we found out in the discussion of state regulation of insurance, the rationale for regulation of insurance industry has two primary aspects – protection of the consumers against unfair practices or market mis-conduct of insurers and protection of the consumers against losses arising from the insolvency of insurers. Hence, the fundamental objective of insurance regulation is to ensure the financial soundness of the insurance companies and their capital, reserves and investments; and to ensure that policyholders and beneficiaries are given fair and reasonable treatment by insurance companies and insurance agents.

As has been mentioned above, those adhering to the conventional notions of economic efficiency hold the view that regulation of insurance should be advocated if the competitive market fails to provide a constrained optimum, and the objective of the regulator should be to reach outcomes which are constrained optimum. However, in practice, even the most developed countries do not adhere to this view of regulating a competitive insurance industry with the objective of achieving 'efficiency' in the

allocations in the market. This point becomes evident from the legal responses of the state to the issue of market fragmentation by insurers for coping with the problem of adverse selection, which have come up in the developed countries, like, the United States. The evidence from such countries suggests that even when the government allows the insurers to take resort to classification of the customers, which in turn leads to fragmentation of the market on the basis of risk exposure of individuals (a phenomenon that we referred to as unpooling of risks), it does take care to make it mandatory for the private insurers to provide insurance coverage to those individuals who get excluded from the market for voluntary private insurance, and that too at rates regulated by the state regulatory authorities.

The insurance markets in the U.S. and the European Union are the two largest competitive markets for insurance, characterised by the presence of a sufficiently large number of private insurers competing with each other in identical lines of business. However, the regulatory authorities in neither of the two seem to adhere to the view that the force of competition can discipline the insurance companies and ensure the safeguarding of the consumers' interest. Japan, on the other hand, has protected its insurance industry from a liberal and competitive environment for long through very tough regulatory measures. The remarkably high levels of insurance penetration and insurance density in Japan provides a sharp criticism of the arguments put forward by the advocates of deregulation/liberal regulation of the insurance industry that a liberal regulatory regime is essential for achieving a matured insurance industry. China's experience with liberalisation and regulation of insurance shows a very cautious approach to replacing the existing nationalised insurance industry with a competitive one and towards allowing foreign insurers entry to the domestic market, both of which can be detrimental for a developing economy when these changes are implemented hastily. And, Poland offers an important evidence of a country undertaking full-scale liberalisation of the existing nationalised insurance industry accompanied with a liberal regulatory regime, and then paying the price for it.

The insurance industry in India prior to its nationalisation was characterised by dismal performance by the private insurance companies. The growing instances of market

misconduct by the insurers, as also the increasing number of insolvencies, led to the nationalisation of life insurance business in 1956 and that of general insurance in 1972. The nationalisation of India's insurance industry, apart from protecting the interests of the policyholders, was also visualized to play a key role in channelising public savings for nation-building. LIC has become successful, over the four and a half decades of its existence, in numerous ways. One of the most commendable feats of LIC, over the period of its existence, has been its crucial role in mobilising savings for investments in development of infrastructure and other socially prioritised avenues in the country. LIC's claim-settlement ratio has been above 90 per cent, over the years, while the world average for claim settlement ratio has been around 40 percent only (both in life and non-life insurance). The performance of the GIC has been less impressive than that of LIC. However, the claim settlement ratio of GIC had been around 74 percent, which is much higher than the world average of around 40 percent, and it had been investing 50 percent or more of its investible surpluses in mandated areas of development. The strongest criticism of the nationalised insurance industry was made on the basis of India's very low levels of insurance penetration and insurance density in comparison to those of the developed countries and some of the developing countries. However, the insurance density, which expresses the total volume of insurance premiums in a year in per capita terms, is bound to be low when, for a given level of insurance premiums, the population of a country is high. Thus, insurance penetration, which expresses the total volume of insurance premiums in a year as a percentage of the Gross Domestic Product of the country, is relatively better as a parameter for judging the performance of a country's insurance industry. However, there exists no strong argument to prove that the relationship between the national income of a country and its total volume of insurance premiums is a linear one. If we consider two countries with different levels of per capita income and also with different levels of inequality in the distribution of the national income, the insurance penetration cannot be taken as an indicator to compare the performance of the insurance industries in the two countries, for the country with a higher level of per capita income combined with a lower level of disparity in the distribution of its income can be expected to have a higher level of insurance penetration when the

structure and performance of the insurance industries in both the countries have been identical.

In case of India, the philosophy of the governments at the Centre during the last decade as well as that of the regulators of insurance (after the setting up of IRDA in 2000) regarding the business of insurance seems to have been that —a free, competitive insurance market generally leads to lower premium rates, better risk coverage and better products to deal with the growing needs of the insurance buying public; however, there has to be some degree of intervention in that free market to ensure that there is 'fair' competition and not 'cut-throat' competition that can lead to insolvencies of insurers. While the second part of this philosophy is correct, the first part is fallacious.

In India, the authority to regulate insurance is centralized with IRDA and the Central Government. The IRDA Act clearly mentions that, in questions of policy, IRDA is bound to obey the decisions of the Central Government. This restriction might constrain the ability of IRDA to take decisions on key issues that might have a significant bearing on the interests of consumers in the insurance market. IRDA is merely a law-implementing body, which is bound by the areas of regulation that have been provided for in the IRDA Act.

Many of the loopholes in the regulatory regime for insurance in India seem to be rooted in the dual responsibility given to the regulatory authority, i.e., of protecting the interests of the insurance policyholders as well as ensuring growth of insurance business in the country. The IRDA is trying to put in place a liberal and competitive environment in the insurance industry so as to help the new, private insurance companies register appreciable growth and compete with the incumbent public sector insurers. The current system of regulation under IRDA covers many important aspects of the business of insurance as well as the specific needs in case of India, but many of the regulatory measures are weak and the approach is towards a more flexible regime in future.

As regards allowing the formation of insurance co-operatives and IRDA's regulations for such entities, while the intention of IRDA is to protect the insureds from insolvency of co-operatives it ignores the fact that insurance co-operatives of very small size targeting

certain sections of the population in the rural areas can be highly beneficial for people in the rural areas, but such co-operatives will never come into existence under the current regulations. And, it should be noted that the Insurance Amendment Act 2002 (which allowed the formation of insurance co-operatives in India) has given authority to IRDA to exempt the co-operatives from any of its regulations. The loopholes in the IRDA Act regarding rural and social sector obligations of the new insurance companies have been carried over fully into the regulations of IRDA. By specifying merely the percentage of business to be covered in the rural areas by the insurers, the problem of growing disparity between the economic abilities of different regions of the country has been grossly ignored. Also, the number of lives to be covered by the insurance companies so as to fulfil their social sector obligations is grossly inadequate.

There is no legislation in India that provides for underwriting restrictions on insurers, which is a major drawback in the Indian regulatory regime. As a result of the flexibility given to the insurers in risk underwriting, they can be expected to indulge heavily in discrimination among the potential customers resulting in fragmentation of the market for insurance in India. Given the relatively high levels of socio-economic inequality among the people of this country, the sections of the population who are more vulnerable to losses can be expected to belong to the economically poorer strata. In such a scenario, if the private insurers are not restricted from discriminating against less profitable potential customers, a sizable chunk of the country's population will get excluded from the voluntary market for private insurance. The approach of Indian regulators towards rate regulation in insurance seems to be the weakest part in the Indian regime. Following the recommendations of the Malhotra Committee, a substantial portion of the general insurance business in India has already been de-tariffed. And, the developments vis-à-vis the Tariff Advisory Committee are clearly towards de-tariffing a major part of the general insurance business. The consequences of such deregulation can be quite adverse for the consumers.

In the area of market regulation, the approach of IRDA is towards establishing self-regulation by the insurance industry. IRDA's primary objective should be to protect the consumers, which will always be better ensured if market regulation is implemented by government authorities.

The opening up of the insurance market to domestic and foreign private players has resulted in a shrinking of the policy space available to the state in India vis-à-vis the insurance industry. When the new private insurers are competing for market share with the incumbent public sector insurers, with the expectation that the Government would make the environment in the insurance industry more and more conducive to their growth, promotion of public welfare through measures such as cross-subsidisation by the public sector insurers would become quite difficult in this liberalised environment. In such a scenario, IRDA, as the insurance regulatory authority, should not only take strong measures to ensure the protection of the existing insurance policyholders but it should also take up the responsibility for ensuring the availability of insurance coverage at affordable prices and in an indiscriminate manner to all potential buyers of insurance in the country.

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