INSTITUTE OF ACTUARIES OF INDIA

SA1– Health and Care

November 2025 Examination

Indicative Solution

Introduction

The indicative solution has been written by the Examiners with the aim of helping candidates. The solutions given are only indicative. It is realized that there could be other points as valid answers and examiner have given credit for any alternative approach or interpretation which they consider to be reasonable.

Solution 1:

Complaint 1: Unexplained Claims Deduction

1. Understand the Economic and Commercial Environment

India's health insurance market is growing rapidly, yet consumer trust remains fragile. Rising hospitalization costs and complex policy structures have led to increased scrutiny of claim settlements. Insurers face pressure to manage loss ratios while maintaining customer satisfaction.

2. Professionalism

Insurance companies must maintain transparency and fairness in product design and claims process. Undue, unreasonable or Unexplained deductions violate the principle of treating customers fairly and may erode brand image in the long-term.

3. Specify the Problem

Customers complaint was related to partial claim settlements without clear justification. These deductions often lack transparency, leading to disputes and dissatisfaction.

4. Develop a Solution

1) **Implement a standardized claims audit framework with clear deduction categories:**
   A uniform audit structure should be established across all product lines, defining permissible deductions such as non-payable items, room rent limits, co-payments, and disease-specific sub-limits. This framework must be embedded into the claims engine and reviewed periodically to ensure consistency as per policy terms and conditions and compliance with IRDAI guidelines.

2) **Revise policy wording to simplify exclusions and sub-limits**
   Policy documents should be rewritten using plain language. Customers often struggle with legal jargon—summary tables, illustrations and real-life examples can make exclusions and limits more understandable, reducing post-claim disputes.

3) **Provide Pre-Claim Estimation Tool:**
   Create a calculator or simulator allowing customers to preview potential deductions based on treatment type and hospital. This sets realistic expectations and reduces surprise at settlement.

4) **Customer Information Sheet:**
   Insurer should provide FAQs, and illustrative case studies that explain typical deduction scenarios in the Customer Information sheet (CIS). This proactive awareness builds trust and reduces grievance volumes.

5) **Claims Summary Sheet:**
   Every claim settlement must include a line-by-line breakdown of deductions with clear justifications. This should be standardized across insurers and made mandatory to ensure transparency.

6) **Monitoring claims deductions:**
   Machine learning models can analyse historical claims data to detect anomalies in deduction patterns. Claims flagged as inconsistent should be escalated for manual review, ensuring fairness and consistency.

7) **Introduce post-claim feedback surveys:**
Structured feedback should be collected after each claim settlement to assess customer understanding and satisfaction. This data can be used to refine deduction logic and improve communication.

8) **Train claims and customer service teams to communicate deductions clearly**
Claims team must be trained not just in technical policy interpretation but also in empathetic communication. Role-play exercises and customer simulations can enhance their effectiveness.

9) **Grievance Redressal platform:**
A secure online platform should allow customers to contest deductions, upload supporting documents, and track resolution progress. This improves accountability and reduces turnaround time.

10) **Benchmark deduction patterns across insurers**
Industry-wide benchmarking of deduction trends should be conducted and shared with regulators. This fosters transparency and encourages best practices.

5. Monitor the Experience

Track deduction-related complaints, reversal rates, and post-settlement satisfaction scores. Benchmark against industry averages.

6. Feedback and Refinement

Use customer feedback and dispute outcomes to refine deduction logic, improve training, and update policy documentation.

(Max 10 Marks)

Complaint 2: Delay in Claims Payment

1. Understand the Economic and Commercial Environment

Timely claims settlement is a key differentiator in India's competitive health insurance market. Delays can lead to financial distress for customers and reputational damage for insurers. [2 Marks]

2. Professionalism

Actuaries must ensure operational efficiency aligns with policyholder expectations. Delays in payment compromise the insurer's promise of financial protection.

3. Specify the Problem

Customers face prolonged delays in reimbursement and cashless approvals, especially during emergencies**.**

4. Develop a Solution

1) **Set internal turnaround time (TAT) benchmarks**
Define SLAs for each claim type—routine, emergency, high-value—and monitor adherence rigorously. These benchmarks should be published internally and externally to build trust and accountability.

2) **Enable digital claims submission with real-time tracking**
   Upgrade digital infrastructure to allow seamless claim submission via mobile apps and web portals. Real-time tracking should be available to customers, with status updates at each stage.

3) **Automate low-risk claims using straight-through processing**
   STP should be applied to claims below a certain threshold or for predefined procedures. This reduces manual workload and accelerates settlement timelines.

4) **Integrate hospital systems for direct billing data**
   Establish secure APIs with hospital billing systems to receive treatment data instantly. This minimizes paperwork and speeds up verification.

5) **Use predictive models for workload management**
   Apply forecasting models to predict claim volumes and allocate resources dynamically. This ensures adequate staffing during peak periods and reduces bottlenecks.

6) **Provide a clear escalation matrix for delays**
   Publish a transparent escalation path, including contact details of nodal officers. This empowers customers to seek timely redressal and improves accountability.

7) **Send real-time status updates via SMS/email**
   Automated notifications should be triggered at key stages—claim received, under review, approved—to keep customers informed and reduce anxiety.

8) **Assign claims concierge for complex cases**
   For high-value or medically complex claims, assign a dedicated claims concierge to guide the customer through the process. This enhances service quality and builds trust.

9) **Offer compensation for excessive delays**
   Introduce a goodwill compensation policy for claims delayed beyond SLA. This could include interest reimbursement or loyalty credits.

10) **Report delay metrics to IRDAI**
    Submit quarterly reports on claim processing times to the regulator. This promotes transparency and encourages industry-wide improvements.

5. Monitor the Experience

Measure average processing time, percentage of claims settled within SLA, and customer satisfaction scores.

6. Feedback and Refinement

Analyse delay patterns and customer feedback to refine STP rules, staffing models, and escalation protocols.

(Max 10 Marks)

Complaint 3: Delay in Hospital Discharge Due to Authorization

1. Understand the Economic and Commercial Environment

Cashless hospitalization is a key value proposition in Indian health insurance. Delays in discharge authorization increase hospital costs and customer frustration.

2. Professionalism

Actuaries must ensure service delivery matches policy promises. Delays in discharge reflect poor coordination and breach customer trust.

3. Specify the Problem

Patients experience extended hospital stays due to insurer delays in issuing discharge authorizations.

4. Develop a Solution

1) **Define and enforce pre-authorization SLAs**
   Establish strict SLAs for discharge authorizations and embed them in hospital contracts. Monitor compliance through automated dashboards and penalize repeated breaches.

2) **Prioritize integration with high-volume hospitals**
   Digitally integrate with hospitals that generate high claim volumes. Real-time coordination reduces delays and improves operational efficiency.

3) **Enable auto-approval for standard procedures**
   For routine surgeries and treatments, implement auto-approval protocols based on predefined clinical criteria. This bypasses manual authorization and speeds up discharge.

4) **Digitize the authorization process**
   Replace manual workflows with secure, app-based systems that allow hospitals to submit requests and receive approvals digitally.

5) **Ensure 24/7 claims desk availability**
   Maintain round-the-clock claims support, especially in tertiary care hospitals. This is critical for emergency discharges and weekend operations.

6) **Initiate pre-discharge alerts from hospitals**
   Hospitals should notify insurers 6–12 hours before expected discharge. This allows insurers to prepare approvals proactively and avoid last-minute delays.

7) **Notify patients of discharge status via app**
   Provide real-time updates to patients on discharge status and expected timelines. This improves transparency and reduces anxiety.

8) **Include SLAs in hospital MOUs**
   Embed discharge SLAs in formal agreements with network hospitals. Non-compliance should trigger penalties or performance reviews.

9) **Use discharge simulation models for forecasting**
   Apply predictive analytics to anticipate discharge volumes and allocate resources accordingly. This improves operational readiness.

10) **Collect hospital feedback on insurer responsiveness**
    Conduct structured feedback surveys with hospital administrators to assess insurer performance and identify areas for improvement.

5. Monitor the Experience

Track average discharge delay time, hospital escalations, and reduction in discharge-related complaints.

6. Feedback and Refinement

Collect feedback from hospital administrators and patients to refine SLAs, improve integration, and enhance discharge protocols.

(Max 10 Marks)

Complaint 4: Annual Premium Increase Without Justification

1. Understand the Economic and Commercial Environment

Medical inflation and aging risk pools drive premium increases. However, customers expect transparency and fairness, especially when they haven't made claims.

2. Professionalism

Actuaries must balance commercial viability with ethical pricing. Unexplained hikes violate principles of fairness and informed consent.

3. Specify the Problem

Customers are dissatisfied with annual premium hikes, particularly when no claims have been made.

4. Develop a Solution

1) **Communicate premium drivers transparently**
   Explain the rationale behind premium hikes—medical inflation, age progression, and risk pool dynamics—using clear, customer-friendly language. Include personalized examples where possible.

2) **Offer no-claim bonuses or benefit enhancements**
   Reward customers who haven't made claims with discounts, enhanced coverage, or loyalty points. This incentivizes healthy behaviour and retention.

3) **Introduce loyalty tiers with capped increases**
   Segment customers into loyalty tiers based on tenure and claim history. Cap premium increases for long-term policyholders to promote retention.

4) **Explore usage-based pricing models**
   Develop pricing models where premiums reflect actual healthcare utilization. This aligns pricing with risk and promotes fairness.

5) **Segment customers using risk-based pricing**
   Use underwriting data to personalize pricing based on health indicators, lifestyle, and demographics. This improves risk pooling efficiency.

6) **Provide personalized premium review reports**
Send annual summaries comparing individual premium changes to peer benchmarks. This builds transparency and trust.

7) **Benchmark hikes against industry averages**
Publish comparative premium trends across insurers. This helps customers make informed decisions and promotes healthy competition.

8) **Offer flexible deductibles to reduce premiums**
Allow customers to adjust deductibles to manage premium costs. This empowers them to tailor coverage to their financial needs.

9) **Link discounts to wellness program participation**
Offer premium discounts to customers who participate in preventive health programs. This promotes wellness and reduces long-term claims.

10) **Monitor churn due to pricing dissatisfaction**
Track attrition rates and conduct exit interviews to understand pricing dissatisfaction. Use insights to refine pricing strategy.

5. Monitor the Experience
Track churn rates, uptake of loyalty discounts, and complaints related to pricing transparency.

6. Feedback and Refinement
Conduct exit interviews and analyse customer feedback to refine pricing strategy and improve communication.

(Max 10 Marks)

Complaint 5: Poor Communication and Lack of Transparency

1. Understand the Economic and Commercial Environment
In a digital-first market, customers expect real-time updates and seamless communication. Poor service erodes trust and increases complaints.

2. Professionalism
Actuaries must ensure that product and service delivery are transparent, timely, and customer centric. Communication gaps violate ethical standards of disclosure and support.

3. Specify the Problem
Customers feel uninformed and unsupported during their insurance journey, especially during claims.

4. Develop a Solution

1) **Implement an omnichannel communication strategy**
   Ensure consistent messaging across app, web, call center, and email. Customers should receive timely updates regardless of channel.

2) **Provide real-time claim tracking via app**
   Enable live tracking of claim status through mobile apps and web portals. This reduces uncertainty and improves customer experience.

3) **Use AI chatbots for instant query resolution**
   Deploy intelligent chatbots to handle routine queries instantly. This reduces call center load and improves response time.

4) **Map customer journeys to identify pain points**
   Analyse customer interactions to identify friction points. Redesign workflows to eliminate bottlenecks and improve satisfaction.

5) **Send proactive notifications for key events**
   Automated alerts should be triggered at key stages—claim received, under review, approved—to keep customers informed.

6) **Assign relationship managers for complex cases**
   Provide dedicated support for high-value or vulnerable customers. This enhances service quality and builds trust.

7) **Simplify policy documents with visual aids**
   Redesign policy documents using infographics, plain language, and modular layouts. This improves comprehension and reduces disputes.

8) **Run customer education campaigns**
   Conduct webinars, tutorials, and FAQs to educate customers on policy usage and claims process. This empowers them to navigate insurance confidently.

9) **Use sentiment analysis to detect dissatisfaction**
   Apply NLP tools to detect negative sentiment in customer interactions. Intervene proactively to resolve issues.

10) **Track service quality KPIs**
    Monitor resolution time, first-contact resolution rate, and Customer Satisfaction (CSAT) scores. Use data to drive continuous improvement.

5. Monitor the Experience

Measure reduction in communication-related complaints, improvement in CSAT and NPS, and engagement across digital platforms.

6. Feedback and Refinement

Use sentiment analysis and customer feedback to refine communication strategy, update training, and improve digital tools.

(Max 10 Marks)

[50 Marks]

Solution 2:

a) Reasons Behind the Poor Performance of the PMI portfolio

The recent decline in profitability and volume of in-force business of the Private Medical Insurance (PMI) portfolio is the result of multiple interrelated factors. These span competitive pressures, pricing inadequacies, claims experience, operational inefficiencies, and reserving challenges.

A. Competitive Pressures and Market Dynamics

1. The reduction in in-force business is likely due to a combination of low new business volumes and poor persistency.
2. Increased competition in the PMI market has led to price erosion and customer migration.
3. Competitors are offering similar products at lower premiums, attracting price-sensitive customers.
4. New entrants may be willing to accept lower profits—or even losses—in the short term to build market share.
5. This strategy is sustainable only while capital support or strategic tolerance for losses exists.
6. Some competitors may exit once their portfolios mature and claims increase.
7. These insurers benefit from initial selection effects, where claims are low in early policy years. This is due to exclusions of pre-existing conditions, which delay claim emergence. As policies mature, new conditions arise, increasing claims and require premium adjustments.
8. Currently, new entrants may have a large proportion of younger policyholders in the portfolio, allowing lower premiums. However, premiums will need to rise as morbidity increases with age.
9. They may have a different rating structure or use rating factors not used by the insurer (such as occupation or location) and so attract the type of customers for whom they can offer a lower premium.

    a) If their premium structures accurately reflect the eventual claims the competitors should still, make profits (otherwise they may make losses).
    b) They may mainly target young people. As premiums for younger ages have traditionally been higher than necessary, such insurers may be able to offer cheaper rates (because there are no old people requiring cross subsidies).
    c) This is sustainable for as long as mainly young people are on the insurer's books, but the existing customers will age with time.

10. Some competitors may have inaccurate pricing due to limited data, leading to future losses.
11. Over time, experience will force price corrections or market exit.
12. Competitors may adopt lenient underwriting, accepting risks on prior terms, increasing future claims.

13. Alternatively, they may use stricter underwriting to attract better risks, which is sustainable if cost-effective.
14. Operational efficiency, including use of digital platforms, may reduce acquisition and servicing costs.
15. This efficiency can be sustainable and provide long-term competitive advantage.
16. Competitors may offer more attractive or innovative products, such as wellness benefits or corporate services.
17. Effective marketing and product presentation (e.g., aggressive advertising) can enhance perceived value.
18. Sales force incentives may be better aligned, driving higher conversion and retention.

B. Persistency and Customer Retention

1. High renewal premiums are a major deterrent to persistency.
2. Annual increases often exceed general inflation, making policies unaffordable.
3. Premiums must rise to match increasing claims costs and aging of policyholders.
4. Non-claiming customers may feel disengaged or unrewarded, leading to lapses.
5. Poor customer service, especially around claims handling, can drive cancellations.
6. Negative publicity from mishandled claims may amplify reputational damage.
7. There may be reduced demand for PMI due to improvements in public healthcare.
8. General scepticism or bad press around PMI may suppress new sales.
9. Economic downturns reduce disposable income, making PMI a lower priority.

C. Pricing and Premium Adequacy

1. Premium rates may be insufficient to cover claims, due to competitive or moral pressure.
2. Insurers may be reluctant to raise premiums in line with claims inflation, eroding margins.
3. Changes in business mix may reduce average premium per policy.
4. Customers may downgrade to lower-value products, such as higher excess plans.
5. Smaller family sizes reduce the number of lives covered per policy.
6. These shifts reduce overall premium income and profitability.

D. Claims Experience

1. Claims may be rising due to anti-selection, where pricing does not reflect true risk.
   For example, average age may be increasing, but premiums may not adjust proportionally.
2. Claim frequency may rise due to:
   a) Genuine increase in illness prevalence.
   b) Higher expectations and demand for treatment.
   c) Greater awareness of coverage among policyholders.
   d) Maturing portfolios losing initial selection advantage.
3. Claim severity may rise due to:
   a) Medical inflation—equipment, procedures, and fees rising faster than CPI.
   b) Technological advances—new treatments are often more expensive.
   c) Availability of treatments for previously untreatable conditions.
4. Poor medical underwriting may allow claims for pre-existing conditions.
5. Causes include:
   a) Insufficient medical evidence collection.

b) Inadequate training of underwriting staff.
c) Lowered standards due to cost-cutting.

6. Poor claims control may result in overpayment or inappropriate approvals.
7. Staff cutbacks or poor training may exacerbate this issue.

E. Expenses and Operational Efficiency

1. Administrative expenses may have increased due to complex claims and servicing needs.
2. Attempts to reduce expenses may have compromised service quality, requiring reinvestment.
3. High fixed costs in legacy systems and distribution may limit flexibility.

F. Technical Provisions and Solvency

1. Rising technical provisions despite falling volumes reduce reported profits.
2. Best estimate liabilities may have increased due to:
   a) Changes in model points.
   b) Revised assumptions.
   c) Lower discount rates.
3. Risk margins may have increased due to:
   a) Higher projected capital requirements.
   b) Increased cost-of-capital rates.
   c) Lower discount rates.
   d) Changes in approximation methods.
   e) Reduced diversification benefits.
4. Provisioning errors may arise from:
   a) Inappropriate methodologies.
   b) Use of incorrect or incomplete data.
5. These factors contribute to solvency strain, limiting strategic flexibility.
6. Higher provisions also reduce reported profitability, affecting investor confidence.
7. Without corrective action, these pressures are likely to persist or worsen.

(Max 25 marks)

b) Evaluation of Proposed Initiatives and Suggested Improvements

The marketing department has proposed two initiatives to improve performance:

- offering loyalty-based premium discounts
- launching online sales of PMI products.

Both ideas have strategic merit but require careful evaluation and refinement to ensure they are financially sound, operationally feasible, and aligned with customer expectations.

A. Loyalty Discount

This initiative involves applying a discount to renewal premiums based on the customer's tenure with the insurer, and potentially their claims history.

I. Advantages

1. Encourages long-term retention, helping to stabilize in-force business volumes.

2. Reduces acquisition costs, which are typically higher than retention costs.
3. May attract new customers who value long-term benefits and perceive added value.
4. Reinforces brand loyalty and improves customer lifetime value.
5. Can be positioned as a reward for commitment, enhancing customer satisfaction.
6. A claims-related discount encourages retention of low-risk customers, improving portfolio quality.
7. May discourage small or discretionary claims, reducing administrative costs.
8. Claims history serves as a proxy for health status, aiding future risk assessment.

II. Disadvantages

1. If premiums do not fully reflect age-related claims risk, older customers may be underpriced.
2. As initial selection effects wear off, claims are expected to rise among long-tenured customers.
3. Inflationary increases may overshadow the perceived benefit of the discount.
4. The cost of the discount must be factored into initial pricing, potentially requiring higher premiums for new customers.
5. May introduce cross-subsidies that distort pricing fairness across cohorts.
6. Ethical concerns may arise if customers feel penalized for being ill.
7. Customers may delay seeking treatment to preserve discount eligibility.
8. Defining what constitutes a "claim" can be complex and subjective.
9. The mechanism for assessing eligibility must be transparent and fair.
10. Systems and pricing models must be adapted to accommodate the discount logic.

III. Suggested Improvements

1. Structure the loyalty discount as part of a broader retention strategy, combining it with service enhancements.
2. Cap the discount to preserve pricing adequacy and avoid excessive erosion of margins.
3. Use tiered loyalty bands (e.g., 3, 5, 10 years) to manage cost and reward tenure proportionally.
4. Model the financial impact of the discount across different customer segments and durations.
5. Conduct market research to assess customer understanding and perceived value.
6. Consider integrating wellness engagement as a condition for loyalty rewards.
7. Ensure the discount is simple enough for customers to understand, but actuarially effective.
8. Consider introductory discounts for new customers to offset higher initial premiums.

B. Launching Online Sales of PMI Products

I. Strategic Advantages

1. **Expanded Market Reach**
   Online channels can attract younger, tech-savvy customers who are less likely to engage with traditional agents or brokers.
2. **Lower Acquisition Costs**
   Digital sales reduce reliance on commission-based intermediaries, lowering distribution expenses.

3. **Faster Sales Process**
   Online platforms enable instant quotations, automated underwriting, and quicker policy issuance.
4. **Improved Scalability**
   Once established, digital infrastructure can handle large volumes with minimal marginal cost.
5. **Data-Driven Marketing**
   Online platforms allow targeted campaigns using customer behaviour, location, and demographics.
6. **Brand Modernization**
   A digital presence enhances brand perception, especially among urban and millennial audiences.

II. Operational and Risk Considerations

1. **Reduced Underwriting Depth**
   Less information may be collected at point of sale, limiting risk assessment accuracy.
2. **Higher Risk of Anti-Selection**
   Customers may misrepresent health status or personal details to obtain lower premiums.
3. **Greater Reliance on Moratorium Underwriting**
   To streamline onboarding, insurers may exclude pre-existing conditions without detailed medical checks.
4. **Customer Misunderstanding Risk**
   Without human guidance, customers may misinterpret exclusions, limits, or waiting periods, leading to disputes.
5. **Need for Simplified Product Design**
   Online products must be easy to understand and compare, which may limit customization and coverage depth.
6. **Cybersecurity and Data Privacy**
   Handling sensitive health and financial data online requires robust security protocols and compliance with data protection laws.

III. Actuarial and Commercial Recommendations

1. **Modelling**
   Actuarial projections should assess expected acquisition cost savings, conversion rates, and claims experience under digital onboarding.
2. **Pilot Launch with Controlled Scope**
   Begin with a limited product range or geography to monitor performance and refine processes.
3. **Customer Education and Support Tools**
   Provide interactive guides, FAQs, and chatbot support to ensure informed decision-making and reduce post-sale grievances.

(Max 10 marks)

c) Additional Strategic Actions to Address PMI portfolio Challenges

To restore profitability, improve solvency, and regain market competitiveness, the insurer must take a holistic approach. This includes responding to competitive pressures, redesigning products,

improving customer retention, enhancing operational efficiency, and strengthening financial controls.

A. Responding to Competition

1. Investigate why competitors can offer similar PMI products at lower prices—review their cost structures, underwriting practices, and digital capabilities.
2. Benchmark competitor sales methods, including online platforms, influencer marketing, and aggregator partnerships.
3. Identify which competitor strategies are sustainable and adapt internal processes accordingly.
4. Consider adopting leaner distribution models to reduce acquisition costs.
5. Explore partnerships with digital health platforms to enhance product value.
6. Monitor competitor pricing and product positioning regularly to remain responsive.
7. Evaluate whether competitors are under-pricing due to initial selection effects or aggressive growth targets.
8. Assess whether new entrants are targeting specific demographics (e.g., young urban customers) and replicate successful segmentation.
9. Use competitor intelligence to inform product development and marketing strategy.

B. Product Design and Innovation

1. Introduce lower-cost product variants by reducing benefits, making PMI more affordable for price-sensitive customers.
2. Ensure benefit reductions yield greater savings than perceived value loss.
3. Exclude coverage for certain conditions (e.g., psychiatric treatment) to reduce claims cost.
4. Restrict treatment to select hospitals with negotiated discounts.
5. Cap treatment limits (e.g., six physiotherapy sessions per claim or ₹2,000 per session).
6. Impose annual aggregate limits (e.g., ₹10 lakh per policy year).
7. Link private treatment eligibility to public system wait times (e.g., >6 weeks).
8. Increase excess levels per claim or annually to reduce small claims.
9. Communicate benefit restrictions transparently to avoid dissatisfaction.
10. Carefully select excluded conditions to avoid reputational risk—ensure alternatives exist via public healthcare.
11. Explore cash benefit products offering fixed payouts per event (e.g., ₹1,000 per hospital night).
12. Design products that encourage preventive care and wellness engagement.
13. Tailor products for specific segments—e.g., gig workers, seniors, or families.
14. Pilot new product designs in select markets to test demand and claims behaviour.

C. Improving Persistency and Customer Retention

1. Introduce loyalty discounts and claims-free rewards to incentivize renewals.
2. Use customer feedback to identify pain points in service and claims experience.
3. Offer flexible payment options (e.g., monthly premiums) to improve affordability.
4. Provide personalized renewal communications highlighting benefits and usage.
5. Assign relationship managers for high-value or long-tenured customers.
6. Launch educational campaigns to improve understanding of coverage and value.
7. Monitor lapse rates by segment and intervene with targeted retention offers.

D. Operational and Strategic Improvements

1. Conduct profitability analysis by product and segment to identify loss-making areas.
2. Rebalance the portfolio by reducing exposure to unprofitable sectors.
3. Review distribution channel performance and explore new channels (e.g., bancassurance, digital aggregators).
4. Audit claims handling and underwriting standards to ensure consistency and effectiveness.
5. Invest in staff training to improve service quality and reduce errors.
6. Review administrative expenses and identify areas for cost optimization.
7. Balance cost-cutting with maintaining high service standards to support persistency.
8. Implement dashboards to monitor operational KPIs and trigger corrective actions.

E. Financial Management and Solvency

1. Analyse the drivers of increasing technical provisions—review assumptions, data quality, and methodology.
2. Rectify any errors or inconsistencies in reserving processes.
3. Reassess investment strategy considering solvency pressures and rising liabilities.
4. Shift toward more closely matched assets, such as short-term deposits, to reduce volatility.
5. Monitor solvency ratios regularly and adjust capital strategy as needed.
6. Align financial planning with expected regulatory changes and macroeconomic trends.

(Max 15 marks)

[50 Marks]

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