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INSURANCE UNDERWRITING AND SOCIAL PROTECTION IN ASEAN

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ABSTRACT

Governments that purchase or mandate insurance determine both the risks transferred to an insurer and the losses left with the people they intend to protect. This article examines responsibility for that retained exposure through a functional comparison of insurance and social protection law in Singapore, the Philippines, Malaysia and the Lao People's Democratic Republic. Residual loss is defined against a programme's protective purpose and distinguished from an unpaid contractual or statutory benefit. The distinction connects underwriting disputes to public decisions about coverage and the expenditure of sovereign insurance proceeds. Malaysian disclosure remedies and Philippine restrictions on discriminatory underwriting reveal different evidential demands: reconstructing the insurer's historical response to accurate information and establishing the grounds actually used to exclude an applicant. A constructed index-insurance model further demonstrates that equal expected payments can leave markedly different shortfalls during severe loss. These findings support a proposed duty requiring public authorities to justify foreseeable retained exposure when selecting or renewing insurance and allocating its proceeds. The duty combines preservation of the evidence supporting those choices with review by a body competent to reconsider them. Doing so renders public choices accountable after the insurer has performed, while preserving the distinct remedies through which beneficiaries enforce benefits already owed.

Keywords: insurance law; residual loss; social protection; comparative public law; basis risk; disaster finance

1 INTRODUCTION

In October 2026, the World Bank reported that roughly 65 per cent of a US$2 million sovereign disaster insurance payout received by the Lao People's Democratic Republic (Lao PDR) the preceding year had been disbursed, with payments made for 15 of 39 approved recovery activities.[1] A resident seeking assistance through one of the outstanding activities would have needed to challenge a public decision or seek faster action by the authority responsible for funding or implementation, although the money had originated in an insurance contract. The ministry receiving the payout, the committee choosing recovery projects and the body undertaking the work exercised different powers. Whether the resident could require further action depended on those powers and the domestic rules governing assistance, rather than simply on the fact that the insurer had paid.

Governments make similarly consequential choices before a loss occurs. Selecting a benefit ceiling or an index trigger determines which expenditure the insurer will meet and which expenditure households must finance elsewhere. Retention may be a defensible response to limited public funds, especially where another programme covers the remaining need or broader insurance commands a prohibitive premium. A household's immediate difficulty in paying for treatment or restoring a livelihood, however, may also result from unlawful exclusion or the withholding of a benefit already due. Although the financial consequences can resemble those of deliberately limited cover, a claimant alleging breach relies on a different legal obligation from one questioning the protection a public authority chose to purchase.

Legal and economic scholarship has long recognised that insurance influences conduct beyond the payment of claims. Ben-Shahar and Logue describe insurers' regulatory activity through classification, policy conditions and claims administration.[2] Clarke and Wren-Lewis examine how advance risk financing can mitigate problems of governmental commitment, and Clarke and Dercon develop the relationship between disaster planning and responsibility when agreed procedures fail.[3] For an intended beneficiary, these institutional effects raise a further question about the legal consequences of

[1] World Bank, *Lao PDR: Improved Access to Disaster Risk Financing (P505224), Implementation Status and Results Report*, seq 2, ISR08961 (1 October 2026) 1–2; compare the separate grant-disbursement table at 5 https://documents1.worldbank.org/curated/en/099093026222033260/pdf/P505224-1e32be86-d09e-4f55-bb6c-27f772c7f9b8.pdf.

[2] Omri Ben-Shahar and Kyle D Logue, 'Outsourcing Regulation: How Insurance Reduces Moral Hazard' (2012) 111 *Michigan Law Review* 197, 199–201 https://home.uchicago.edu/omri/pdf/articles/Outsourcing_Regulation.pdf.

[3] Daniel J Clarke and Liam Wren-Lewis, 'Solving Commitment Problems in Disaster Risk Finance' (World Bank Policy Research Working Paper 7720, June 2016) 2–3, 8–11 and 19–22 https://documents1.worldbank.org/curated/en/396511468197075071/pdf/WPS7720.pdf; Daniel J Clarke and Stefan Dercon, *Dull Disasters? How Planning Ahead Will Make a Difference* (Oxford University Press 2016) 3 and 68–69 https://www.gfdrr.org/sites/default/files/publication/dull-disasters.pdf.

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successful risk transfer. The insurer may have met its obligation even though the public purpose for which insurance was purchased remains only partly fulfilled. The rights available at that point depend on how the unmet need arose, including decisions about the original coverage and the subsequent use of insurance proceeds.

Under the ASEAN Declaration on Strengthening Social Protection, governments accept responsibility for the quality and sustainability of social protection, subject to nationally determined conditions. The International Labour Organization's Social Protection Floors Recommendation connects nationally defined guarantees with legislation and accessible complaint procedures.[4] Domestic law determines the enforceable benefits and routes of review available to an intended beneficiary, together with the discretion afforded to the administering authority when reconciling protection with competing demands on public resources. The case for requiring reasons for a coverage decision is strongest where the authority has deliberately assigned a foreseeable loss to beneficiaries whose statutory protection it is responsible for administering, yet the terms of the insurance contract reveal little about that public choice.

The four jurisdictions considered here permit a comparison of these allocations of authority.[5] Singapore's statutory health scheme preserves membership despite exclusion from a private supplement, raising questions about the protection secured through each legal instrument. Philippine restrictions on exclusion because of human immunodeficiency virus (HIV) status and Malaysian remedies for misrepresentation both require scrutiny of underwriting evidence, although the statutes test different aspects of the insurer's conduct. Public financing introduces a further distinction within the Philippines, where the crop insurer's Board controls product design as well as an appeal stage in individual claims. Lao sovereign insurance separates the contractual recipient from the institutions authorising relief. Taken together, these examples show why an insurer's performance settles only the obligation it assumed. I argue for a public duty, enacted through legislation or binding programme rules, to justify foreseeable exposure retained in the design and administration of publicly supported insurance.

2 RESIDUAL LOSS AND THE ALLOCATION OF RESPONSIBILITY

2.1 THE PROTECTIVE PURPOSE AND THE FINANCIAL SHORTFALL

A claim that insurance has left a residual loss presupposes a standard of protection against which the beneficiary's unmet expenditure is measured. The sum payable under a policy measures performance of the insurer's promise, whereas a programme intended to secure medical treatment or enable replanting may be judged against the expenditure required to achieve that purpose. A policy can meet its terms despite leaving that expenditure partly unfunded. Equally, a sovereign policy purchased to provide immediate liquidity may fulfil its assigned role within a recovery plan financed through several sources. Assessing the adequacy of insurance therefore requires the programme's protective purpose to be specified, including the contribution expected from other resources. Otherwise, criticism of a policy ceiling risks assuming that the insurer was contracted to meet a need that the public purchaser intended to finance separately.

Residual loss is used here for the financial remainder, or the associated unmet recovery need, measured against that stated purpose at a stated time. Familiar insurance mechanisms explain much of it. An insured person may retain a deductible or expenditure above a benefit limit; an index may fail to trigger despite substantial damage. An applicant refused admission has no entitlement under the proposed contract, but may have a statutory claim concerning the ground of refusal. Once a covered benefit has accrued, failure to pay engages the existing obligation and its payment conditions. Grouping these circumstances under residual loss permits examination of the protection reaching the beneficiary while retaining the legal distinctions on which enforcement depends.

For a single period, let L represent realised financial loss and P the insurance payment received by the beneficiary or paid on the beneficiary's behalf. After separate public assistance A has been applied to that loss, positive uncovered loss is $\max(L - P - A, 0)$. This quantity differs from the signed balance $L - P - A$, which permits a payment in a no-loss state to offset a deficit in a loss state when averages are calculated. Equal or closely matched expected values $E[L]$ and $E[P]$ are consistent with very different protection during individual events because those expectations do not identify the joint distribution of loss and payment.

An accrued benefit requires a separate notation. If C is the sum legally due under the policy or statute, $\max(C - P, 0)$ identifies an unpaid entitlement once the payment date has passed. A claimant seeking that amount relies on the promise and satisfaction of its conditions, whereas a complaint that $\max(L - P - A, 0)$ remains too large depends on the standard of protection against which the programme is being assessed. Both complaints can arise from the same illness or flood. Reducing them to a single allegation of inadequate insurance would obscure the stronger claim to payment where the beneficiary has already fulfilled the contractual or statutory requirements.

These measures must be applied at the level at which the loss is borne. Crediting a sovereign payout against a household's loss before relief becomes available confuses public liquidity with private resources. Deducting both the treasury receipt and assistance financed from it counts the same funds twice. Where a programme provides treatment or agricultural services in kind, timely access may also be a more useful measure than a cash valuation: reimbursement after the treatment or planting deadline can leave the intended protective purpose unfulfilled. A household borrowing in the interim incurs interest

[4] ASEAN Declaration on Strengthening Social Protection (9 October 2013), introductory qualification and principles 4–5, 8 and 10, in ASEAN Secretariat, *ASEAN Documents Series 2013* (2014) 30–32, especially 31 https://asean.org/wp-content/uploads/2022/09/11.-November-2014-ASEAN-Documents-Series-2013.pdf; International Labour Organization, Social Protection Floors Recommendation, 2012 (No 202), paras 3, 7 and 9, in *Building Social Protection Systems: International Standards and Human Rights Instruments* (ILO 2021) 132–133 https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@ed_protect/@soc_sec/documents/publication/wcms_651219.pdf.

[5] MediShield Life Scheme Act 2015 (Singapore) (2020 Rev Ed), s 3; Philippine HIV and AIDS Policy Act, Republic Act No 11166, ss 42 and 49(f); Presidential Decree No 1467 (Philippines), as amended by Republic Act No 8175; Financial Services Act 2013 (Malaysia) (Act 758), sch 9, paras 7 and 16; Law on Disaster Management No 71/NA (Lao PDR), arts 43 and 45–47.

and charges, whose recovery depends on the governing duty and rules of causation. Repayment of principal is not an additional loss, and the use of existing savings finances current expenditure by reducing reserves available for later needs.

2.2 RETAINED RISK AND ACCRUED RIGHTS

The legal consequences of a shortfall follow from the obligation allegedly left unperformed. If a farmer's damage exceeds the policy ceiling, accurate adjustment and timely payment may exhaust the insurer's undertaking even though the farmer lacks the funds to replant. A challenge to that ceiling concerns the statutory powers under which the product was selected and the conditions attached to its public financing. The public purchaser can reconsider the coverage it buys; increasing the private insurer's liability beyond the agreed limit requires a separate legal basis. By contrast, where a regional office has failed to release an approved indemnity, the farmer can pursue the accrued benefit through the claims procedure. A dispute about the design of future cover should not postpone enforcement of the payment already owed.

The difference also governs the evidence that a reviewing body needs. The farmer seeking payment must establish the approval and the sum outstanding. To contest a publicly chosen ceiling, the farmer needs access to the authority's powers and the basis for their exercise, including any statutory restriction on retained exposure. If existing law provides no right to reasons or reconsideration, a proposal to confer one must identify the decision to which it attaches and the body capable of granting effective relief.

Product selection must also be judged at the time of the decision. A government may reasonably purchase modest cover for a broad population when its budget cannot finance full recovery for everyone. The later occurrence of a severe loss is consistent with such a choice, provided the retained risk was within the authority's powers and had been assessed against feasible alternatives. Persisting with the same product after repeated operational failures raises a different issue. Contemporaneous design records allow a reviewer to distinguish a foreseeable tail loss from the collapse of an assumption on which the authority relied, and to examine whether renewal took proper account of the evidence that had since become available.

2.3 THE BASIS OF COMPARISON

The comparison turns on powers over exposure that are distributed differently across the schemes. In a retail contract, the insurer ordinarily determines admission and applies its policy terms within statutory constraints. A subsidised programme may give a public board control over both the product and claims administration, as PCIC illustrates. Under sovereign insurance, the treasury receives a payment whose use depends on a further set of public decisions. These differences make the identity of the beneficiary, premium payer and contractual recipient indispensable to an analysis of responsibility. They also explain why the review powers needed to correct an underwriting error may be inadequate to reconsider a public allocation.

The private-law examples identify the evidence through which policyholders can contest underwriting. Public purchasers exercise a different set of powers over programme design and financing, so the proposed obligation requires a domestic public-law foundation appropriate to those powers.

3 UNDERWRITING INFORMATION AND THE PROOF OF INSURANCE DECISIONS

3.1 ACTUARIAL CREDIBILITY AND THE PRICE OF INCLUSION

An insurer pricing cover for a previously excluded population must estimate claims that its existing portfolio has never recorded. Payments made under narrower policy terms reflect the exclusions and benefit limits then in force; extending those observations to broader cover requires assumptions about both the omitted expenditure and the newly admitted risks. For a public authority financing inclusion, the source of a high premium therefore affects the intervention it can sensibly adopt. Better information may reduce uncertainty about claims, whereas a subsidy addresses the affordability of the premium ultimately charged.

Actuarial credibility theory describes the dependence of an estimate on the reference population when individual experience is sparse.[6] In Bühlmann's model, observations conditional on a risk parameter Θ have common mean $\mu(\Theta)$, variance $v(\Theta)$ and zero conditional cross-covariances. With finite second moments, $m = E[\mu(\Theta)]$ denotes the collective mean, $v = E[v(\Theta)]$ expected process variance and $a = \mathrm{Var}[\mu(\Theta)]$ the variance of hypothetical means. For $a > 0$ and n equally exposed observations, the credibility weight is:

$$Z = \frac{n}{n + K}, \qquad K = \frac{v}{a}$$

The estimate combines the individual sample mean and m with weights Z and $1 - Z$. Bühlmann–Straub accommodates unequal exposures by weighting observations and adjusting their conditional variances. At a fixed positive K, more observations increase the weight Z. For a given individual sample mean, greater credibility raises the estimate if that mean exceeds m and lowers it if the mean falls below m. An applicant with little claims history is therefore rated principally against the collective to which the underwriter has assigned the risk.

[6] Hans Bühlmann, 'Experience Rating and Credibility' (1967) 4(3) *ASTIN Bulletin* 199, 204–207 https://www.casact.org/sites/default/files/database/astin_vol4no3_199.pdf; Hans Bühlmann and Erwin Straub, 'Glaubwürdigkeit für Schadensätze' (1970) 70 *Mitteilungen der Vereinigung Schweizerischer Versicherungsmathematiker* 111, 114, 116–118 and 123–125 https://doi.org/10.5169/seals-967024.

Bayesian prediction incorporates parameter uncertainty through the posterior distribution; in the normal–normal example discussed by Rachev and his co-authors, the posterior mean likewise combines prior and observed information.[7] Commercial pricing requires further provision for expenses and risk. Wang's distortion operator models the latter through a transformation of the loss distribution whose parameter determines the risk adjustment.[8] A public purchaser can therefore distinguish the estimate of expected claims from provision for expenses and the insurer's charge for bearing risk. Requiring those components to be identified permits scrutiny of what a subsidy finances and of the evidence used to exclude a population or restrict its cover.

3.2 HISTORICAL UNDERWRITING COUNTERFACTUALS IN MALAYSIAN LAW

Under Schedule 9 to Malaysia's Financial Services Act 2013, an insurer seeking a remedy for misrepresentation must establish a breach within the applicable statutory category. For an individual entering, varying or renewing insurance wholly outside trade, business or profession, paragraph 5 imposes reasonable care in responding to the insurer's questions, together with a qualified duty concerning other matters known to affect underwriting. The insurer's conduct in obtaining that information forms part of the inquiry: paragraph 6(1)(c) makes the clarity and specificity of its questions relevant to reasonable care, and paragraph 5(6) deems compliance waived where an unanswered, incomplete or irrelevant response is left unpursued. Paragraph 5(5) separately addresses failure to request the prescribed information or confirmation.[9] An allegation of deficient disclosure must therefore be tested against the application actually presented to the consumer, including the insurer's treatment of gaps in the response.

For consumer general insurance and consumer life policies in effect for two years or less, the remedies appear in Part 3, Division 2 of Schedule 9. Paragraph 7(2) requires both the specified breach and proof that accurate information would have caused the insurer to refuse entry, variation or renewal, or to agree only on different terms. An insurer proving deliberate or reckless misrepresentation on the balance of probability may avoid the contract and refuse all claims under paragraph 15. For careless or innocent misrepresentation, paragraph 16 links relief to the underwriting counterfactual: refusal on any terms permits avoidance with return of premiums; other terms may be applied to the contract, and a higher premium may justify proportionate reduction of a claim.[10] The insurer must reconstruct its own underwriting practice at the time of the disputed transaction. A justification devised using current actuarial assumptions may describe a defensible contemporary price without proving what that insurer would then have charged.

Historical underwriting manuals and model versions are therefore potentially decisive evidence, especially where the asserted rule allowed exceptions. Reprocessing an application through a subsequently revised model risks substituting a later risk appetite for the one governing the contract. More specific retention rules, coupled with confidential production where necessary, could help courts and supervisors test the insurer's reconstruction. For life policies in force for more than two years during the life insured's lifetime, paragraph 13 restricts avoidance on its listed pre-contractual grounds to material fraud, whether or not the policies are consumer contracts. The consumer definition also excludes cover bought for business purposes, including by a smallholder with limited bargaining power.[11]

Bank Negara Malaysia addresses some of that vulnerability through its March 2024 Fair Treatment of Financial Consumers policy, which includes micro and small businesses within its regulatory scope. The vulnerable-consumer provisions, effective from 1 April 2025, extend to natural persons running those businesses. Mandatory standards require firms to assess vulnerable consumers' needs, accommodate them in product design and communicate intelligibly, with non-binding guidance marked separately.[12] An authorised requirement to state adverse underwriting grounds and retain the supporting evidence could develop that supervisory framework. Public purchasers face a related evidential problem when they defend a restrictive coverage choice: preserving the original appraisal enables a reviewer to distinguish the reasons for selection from a rationale constructed after an uninsured loss.

4 ADMISSION, CONTINUITY AND THE LIMITS OF RISK SELECTION

4.1 STATUTORY HEALTH COVER AND PRIVATE RENEWAL RIGHTS IN SINGAPORE

Singapore's MediShield Life Scheme Act 2015 removes individual underwriting from the basic decision to admit citizens and permanent residents. Section 3 establishes their membership under a scheme administered by the Central Provident Fund (CPF) Board, so refusal of a private supplement leaves the statutory benefit intact. Admission nevertheless coexists with differentiated financing: section 4(1B) authorises distinctions between insured classes, and regulation 9 prescribes additional premiums for specified pre-existing conditions. Payment for claimable inpatient and outpatient treatment remains governed by the statutory benefit rules.[13]

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7 Svetlozar T Rachev, John S J Hsu, Biliana S Bagasheva and Frank J Fabozzi, *Bayesian Methods in Finance* (John Wiley & Sons 2008) 22–23, 35–37, especially eqs (3.20) and (3.23) https://doi.org/10.1002/9781119202141; Bühlmann (n 6) 204–207.

8 Shaun S Wang, 'A Class of Distortion Operators for Pricing Financial and Insurance Risks' (2000) 67(1) *Journal of Risk and Insurance* 15, 17–22, 28 and 32–33 https://doi.org/10.2307/253675; Bühlmann and Straub (n 6) 114.

9 Financial Services Act 2013, s 129 and sch 9, paras 2, 4, 5(1)–(9) and 6(1)–(3), Attorney General's Chambers updated text as at 2 January 2025, 276–278 https://lom.agc.gov.my/ilims/upload/portal/akta/outputaktap/3252974_BI/ACT%20758%20%20AS%20AT%202025.pdf.

10 Financial Services Act 2013, sch 9, paras 7(1)(b)–(8) and 14–16, especially paras 7(2)(b), 7(7) and 16(2)–(4).

11 Financial Services Act 2013, sch 9, paras 2, 7(1) and 13(1)–(3); on regulatory standard-setting powers, s 123(1)–(3).

12 Bank Negara Malaysia, *Fair Treatment of Financial Consumers* (BNM/RH/PD 028-103, 27 March 2024), paras 3.1–3.2, 4.1, 5.2 (including fn 4), 7.1, 16.2, 16.5 and 16.26 https://www.bnm.gov.my/documents/20124/938039/pd-ftfc-mar24.pdf.

13 MediShield Life Scheme Act 2015, ss 3(1)–(3) and 4(1A)–(1B) https://sso.agc.gov.sg/Act/MLSA2015; MediShield Life Scheme Regulations 2015, S 622/2015, rr 8–9 https://sso.agc.gov.sg/SL/MLSA2015-S622-2015.

Amendments in 2025 raised the aggregate claim limit from S$150,000 to S$200,000 for admissions on or after 1 April. For approved outpatient treatment received on or after 1 June 2026, the regulations also prescribe an insured contribution of S$500 in an insurance period. The defined category includes renal dialysis, cancer drug treatment and radiotherapy, post-transplant immunosuppression and specified home-based care.[14] Companion MediSave provisions permit additional withdrawals for an insured member or dependant receiving a Ninth Schedule treatment to which that contribution applies. For each paying member, withdrawals for that insured person in an insurance period are capped at the lowest of S$500, the applicable contribution and the member's MediSave credit balance.[15] Households with sufficient savings can use this permission to meet an immediate treatment bill, but the withdrawal reduces their reserves for future healthcare. Its protective effect depends on resources already accumulated by the household.

Private cover introduces contractual exclusions above this statutory floor. Great Eastern's *GREAT SupremeHealth* policy (version AC11/25) excludes pre-existing conditions under clause 4.2.1 unless declared and accepted without exclusion, applies the general exclusions through clause 4.2.2, and preserves the MediShield Life benefit through clause 4.2.3 where the statutory scheme covers a condition excluded privately.[16] A patient may therefore retain basic cover while bearing expenditure excluded by the supplementary contract.

The contract also makes continuity valuable. Subject to its termination and variation provisions, clause 6.2 guarantees renewal upon payment of the premium. Failure to pay within the 60-day grace period terminates cover from the renewal date. Clause 7.1 then makes reinstatement conditional on the insurer's receipt of acceptable evidence of insurability within one year of that date, reserving its discretion to refuse the application. If the insurer approves reinstatement and the required premium is paid, the insurance period runs from the renewal date, but the exclusion covers treatment, medical services and supplies begun before reinstatement, together with later follow-up for the condition treated before that date.[17] A temporary inability to finance premiums can thus expose a policyholder whose health has deteriorated to renewed assessment and exclusions affecting continuing care.

Pauly, Kunreuther and Hirth analyse how premium structures can finance guaranteed renewability against subsequent health reclassification; Cochrane's contingent-settlement model addresses the financing of continued insurance after health changes.[18] For a government considering temporary premium support, the loss of an existing renewal right is consequently part of the cost of lapse. Preserving it may prevent a lasting reduction in supplementary protection, although the authority must weigh that expenditure against the treatment available under MediShield Life and competing uses of the subsidy budget.

4.2 PROTECTED INFORMATION AND HIV-RELATED UNDERWRITING

Insurers may also face restrictions on information that would otherwise inform classification. Singapore's Amended and Restated Moratorium on Genetic Testing and Insurance, issued by the Ministry of Health and the Life Insurance Association (LIA) in June 2025, binds insurers through LIA membership. It prohibits requests for predictive genetic results and adverse use in health insurance and Integrated Shield Plans, permits beneficial use of a disclosed result, and allows adverse use for specified higher-value products only under cumulative product, threshold and approved-test conditions. Diagnostic information, research and national familial hypercholesterolaemia screening receive separate treatment.[19] Compliance depends on the evidence the underwriter actually used. Independently documented clinical findings must be distinguishable from protected predictive information relabelled as a medical condition.

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[14] MediShield Life Scheme (Amendment) Regulations 2025, S 231/2025, rr 1, 6(a)–(b) and 14 https://assets.egazette.gov.sg/2025/Legislative%20Supplements/Subsidiary%20Legislation%20Supplement/231.pdf; MediShield Life Scheme (Amendment) Regulations 2026, S 323/2026, rr 1, 2(a) and 8 (inserting Seventh Schedule pt 5) https://assets.egazette.gov.sg/2026/Legislative%20Supplements/Subsidiary%20Legislation%20Supplement/323.pdf; principal Regulations, r 2 (definition of 'approved outpatient treatment').

[15] Central Provident Fund (Medisave Account Withdrawals) (Amendment) Regulations 2026, S 324/2026, rr 1, 14 and 18, inserting r 21E and the Ninth Schedule https://assets.egazette.gov.sg/2026/Legislative%20Supplements/Subsidiary%20Legislation%20Supplement/324.pdf. Regulation 21E(1)–(4) defines the patient, treatment and contribution conditions and the additional withdrawal limit.

[16] Great Eastern Life Assurance Company Limited, *GREAT SupremeHealth* (sample policy, version AC11/25), cls 2.1 and 4.2.1–4.2.3, 31 and 38–39 https://isomer-user-content.by.gov.sg/3/36d94fb1-7525-4138-9622-580828721291/GREAT%20SupremeHealth_AC1125%20Policy%20Contract_v1.0_%28Sample%29.pdf.

[17] Great Eastern (n 16), cls 5.1, 6.1–6.6 and 7.1–7.3, 39–44, especially cls 6.3 and 7.1.1–7.1.3.

[18] Mark V Pauly, Howard Kunreuther and Richard Hirth, 'Guaranteed Renewability in Insurance' (1995) 10(2) *Journal of Risk and Uncertainty* 143, 144–148 and 150–153 https://doi.org/10.1007/BF01083557; John H Cochrane, 'Time-Consistent Health Insurance' (1995) 103(3) *Journal of Political Economy* 445, 447–451 and 460–461 https://www.johnhcochrane.com/s/Cochrane-time-consistent-health-insurance-JPE.pdf.

[19] Ministry of Health and Life Insurance Association Singapore, *Amended and Restated Moratorium on Genetic Testing and Insurance* (3 June 2025), introduction B–C, paras 2–11 and table 1 https://www.lia.org.sg/media/4588/amended-and-restated-moratorium-2025.pdf. Table 1 sets thresholds at the higher of the applicable 99th-percentile benefit threshold or the fixed floor: S$2 million for life and total permanent disability, S$3,000 monthly for each defined long-term-care category, S$500,000 for critical illness and S$10,000 monthly for disability income, subject to approved-test and aggregation conditions. Paragraph 6 permits beneficial use of a disclosed result; paragraph 10 makes compliance a condition of LIA membership.

The Philippine HIV and AIDS Policy Act imposes statutory restrictions. Section 42 protects private health maintenance organisation (HMO) coverage and private life insurance against denial or deprivation based on HIV status, and delegates implementation to the Insurance Commission. Section 49(f) prohibits exclusion from health, accident or life insurance and credit or loan services 'solely or partially' because of actual, perceived or suspected HIV status, subject to its proviso concerning concealment or misrepresentation upon application.[20] On the interpretation advanced here, an insurer that partly relies on HIV status cannot justify the resulting exclusion merely by identifying another medical concern. The statutory language requires examination of the grounds contributing to the refusal.

Paragraph 2 of Circular Letter No 2019-30 nevertheless permits an HMO to suspend acceptance of a newly diagnosed applicant for up to one year from the start of continuous antiretroviral therapy, to assess adherence and efficacy. Paragraph 7 permits suspension or denial for other impairments that warrant the same outcome irrespective of HIV status.[21] The strongest defence of paragraph 2 rests on the Commission's delegated responsibility to implement access in a market retaining medical underwriting: a clinician's assessment of present stability may require further evidence, and temporary deferral can allow that evidence to emerge. Its lawfulness should therefore depend on the medical ground and the duration imposed, rather than the description 'temporary suspension' alone.

An automatic waiting period triggered by recent diagnosis or treatment presents the harder case. The applicant remains outside the HMO cover sought throughout the postponement, and recent commencement of antiretroviral therapy becomes an operative reason for exclusion. An independently assessed impairment attracting the same deferral in a person without HIV fits paragraph 7's rationale. A fixed period imposed simply because treatment has begun instead engages the prohibition on partial status-based exclusion. Within paragraph 2's one-year maximum, the HMO should be required to support the chosen postponement with identified clinical findings and set a review date suited to those findings.

The Malaysian and Philippine provisions accordingly require different uses of an underwriting file. A Malaysian insurer invoking Schedule 9 must reconstruct the decision it would have made on accurate information, whereas an HMO challenged under section 49(f) must address the considerations on which it actually withheld cover. A hypothetical independent justification cannot resolve whether a prohibited ground contributed to that refusal. In *People v Tuyay*, when examining an additional tax-amnesty exclusion, the Philippine Supreme Court reaffirmed that implementing regulations cannot alter the statute they execute.[22] Applying that principle here depends on construing postponement within the Act's prohibition. The Commission should amend paragraph 2 to require individual clinical criteria applicable irrespective of HIV status, with reasons for the duration and prompt reconsideration as the evidence changes.

5 PUBLICLY SUBSIDISED CROP INSURANCE AND RETAINED AGRICULTURAL LOSSES

5.1 STATUTORY PRODUCT POWERS AND THE CONSEQUENCES OF CLAIMS DELAY

The Philippine Crop Insurance Corporation (PCIC) combines public powers over insurance design with responsibility for settling the farmer's claim. Under Presidential Decree No 1467, as amended by Republic Act No 8175, insurable production costs include agricultural inputs and the farmer's labour, and the Board may extend cover to a portion of expected yield. Section 5 entrusts premium rates and sharing to the Board, subject to Presidential approval and conditions governing support for subsistence farmers cultivating up to seven hectares; section 10.2 permits the Board to refuse or limit cover according to the risk.[23] Executive Order No 60 of 2024 restored the corporation's attachment to the Department of Agriculture for policy coordination.[24] A producer disputing the amount of protection available must therefore distinguish the Board's exercise of these statutory powers from the regional administration of an existing policy.

Government premium subsidies supplied 95.6 per cent of PCIC's premium income in 2021, according to the World Bank's 2023 review. In that year, the corporation issued approximately 2.49 million agricultural policies within a total of 3.36 million across all lines, covering 29 per cent of national rice hectarage and 19 per cent of corn hectarage.[25] These policy counts describe seasonal insurance activity, so they cannot be read as a count of distinct farming households. The review's findings on low sums insured and indemnity calculations varying by crop and cultivation stage are more directly relevant to the depth of

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[20] Philippine HIV and AIDS Policy Act, Republic Act No 11166 (20 December 2018), ss 3(h), 42 and 49(f) https://elibrary.judiciary.gov.ph/thebookshelf/showdocs/2/87423.

[21] Insurance Commission, Circular Letter No 2019-30, *Guidelines in the HMO Underwriting of Applicants with Actual, Perceived, or Suspected Human Immunodeficiency Virus (HIV) Status* (21 June 2019), preamble and paras 2–7 https://site.insurance.gov.ph/wp-content/uploads/2022/09/CL2019_30.pdf; Executive Order No 192 (12 November 2015), s 4 https://elibrary.judiciary.gov.ph/thebookshelf/showdocs/5/65785. Paragraph 6 requires prior Commission approval of specified modifications and retains the non-discrimination condition.

[22] *People v Tuyay*, GR No 206579 (1 December 2021) 917 Phil 10, 19–26, especially 25 https://elibrary.judiciary.gov.ph/thebookshelf/showdocs/1/68168.

[23] Presidential Decree No 1467 (11 June 1978), ss 3.1 and 10.1–10.2 https://elibrary.judiciary.gov.ph/thebookshelf/showdocs/26/14939; ss 1 and 5 as substituted by Republic Act No 8175 (29 December 1995), ss 3 and 5 https://elibrary.judiciary.gov.ph/thebookshelf/showdocs/2/4027.

[24] Executive Order No 60 (13 May 2024), ss 1–2 and 4 https://elibrary.judiciary.gov.ph/thebookshelf/showdocs/5/97388.

[25] World Bank, *Reforming Agricultural Insurance in the Philippines: Review and Roadmap, Technical Report and Recommendations* (2023) 27–28, s 2.6 https://documents1.worldbank.org/curated/en/099011124112030709/pdf/P17115119c158d098191a211c1aee1e3515.pdf; World Bank, *Reforming Agricultural Insurance in the Philippines: Review and Roadmap, Policy Summary and Recommendations* (2023) 14 https://documents1.worldbank.org/curated/en/099011124112021299/pdf/P171151117b571003182b81b4c9d2d91025.pdf.

protection.[26] Where the government finances almost the entire premium, a dispute about how much recovery insurance can fund concerns the use of the subsidy as well as adjustment of the individual loss. A regional officer may calculate the contractual indemnity correctly even though the Board's chosen ceiling leaves the farmer unable to meet the cost that the public programme is intended to address.

Section 11-A of the amended charter gives the farmer recourse through the claims hierarchy. The regional manager or authorised delegate determines settlement, with regional reconsideration available within 30 days of receipt of the decision, followed by recourse to the PCIC President and appeal to the Board. The charter attaches its express 30-day filing period to the regional stage. It also prescribes a substantive consequence for administrative silence: under section 11-A.4, a claim 'shall be considered approved' if PCIC fails to act within 60 days after the submission of complete claim documents.[27] A claimant invoking this provision must establish the date of complete submission and the absence of action during the prescribed period. Clear acknowledgement of the documents received, together with prompt identification of any deficiency, is therefore necessary to make the statutory protection effective in practice.

Once those conditions are satisfied, the claimant can rely on statutory approval in place of an express favourable decision. The remaining interpretive difficulty is its effect on quantum. Section 11-A.4 does not specify whether silence approves the amount requested or establishes liability to be quantified under the policy, so a disputed amount requires the submitted claim, policy terms and legal effect of the approval to be considered together. Where PCIC has already determined a payable sum, the farmer seeks its release; where the corporation has applied a lawful coverage limit, the remaining complaint is about the product's adequacy. Combining those complaints would risk making an existing payment claim await reform of the coverage that public funds will purchase.

The Commission on Audit's report for 2020 recorded claims-processing overruns across PCIC regional offices against operational service standards, and the World Bank review examined delays and administrative weaknesses.[28] Those findings warrant examination through the charter's audit and reporting mechanisms, but the evidence required to invoke section 11-A.4 remains the completion of documents followed by 60 days of inaction. An internal service target may run from a different event. Records separating complete submission from the decision and eventual payment can therefore support both individual enforcement and supervision of recurring delay, particularly where a payment recorded as approved has yet to become available for the next planting season.

5.2 BASIS RISK AND THE DISTRIBUTION OF PROTECTION

Index insurance substitutes a predetermined indicator for assessment of each insured's loss, making the relationship between the trigger and household damage a question of product design. Jensen, Barrett and Mude's research on livestock insurance in northern Kenya examines the household risk that remains when cover responds to an aggregate index.[29] To isolate the consequence for public procurement, consider a constructed single-season example in which two contracts face identical probabilities of severe loss and payment. Premiums and complementary assistance are omitted, and resources cannot be transferred between seasons.

Table 1. Constructed joint probabilities of farm loss and index payment

Outcome	Farm loss L	Payment P	Contract X	Contract Y
Severe loss and trigger	100	80	0.20	0.10
Severe loss without trigger	100	0	0.05	0.15
Trigger without loss	0	80	0.05	0.15
No loss and no trigger	0	0	0.70	0.60

Both distributions sum to one, and each assigns probability 0.25 to severe loss and to payment. Consequently, E[L] = 25 and E[P] = 20 under either contract, with Var(L) = 1,875 and Var(P) = 1,200. Their association differs substantially: Cov(L, P) is 1,100 under X and 300 under Y, giving correlations of 11/15 (approximately 0.733) and 1/5 (0.200). From the variance identity, the net retained-loss variance is 875 under X and 2,475 under Y:[30]

$$Var(L - P) = Var(L) + Var(P) - 2Cov(L, P)$$

For a farmer suffering severe loss, the probability of receiving no payment is 20 per cent under X and 60 per cent under Y. Expected positive uncovered loss conditional on that event is 36 and 68 respectively, while the unconditional quantities E[max(L − P, 0)] are 9 and 17. The signed expectation E[L − P] nevertheless equals 5 under both contracts because, under Y,

[26] World Bank, *Technical Report* (n 25) 39–45, ss 3.4–3.5, especially table 5 at 45.

[27] Presidential Decree No 1467, s 11-A.1–11-A.4, inserted by Republic Act No 8175, s 13.

[28] Commission on Audit, *Annual Audit Report on the Philippine Crop Insurance Corporation for the Years Ended December 31, 2020 and 2019* (2021), pt II, observation 11, 92–95, especially paras 11.1–11.4 and tables 26–27 https://pcic.gov.ph/wp-content/uploads/2021/08/pcic_aar2020.pdf; World Bank, *Technical Report* (n 25) 60–68 and 87; Presidential Decree No 1467, s 12; Republic Act No 8175, s 17.

[29] Nathaniel D Jensen, Christopher B Barrett and Andrew G Mude, 'Index Insurance Quality and Basis Risk: Evidence from Northern Kenya' (2016) 98(5) *American Journal of Agricultural Economics* 1450 https://doi.org/10.1093/ajae/aaw046; authors' manuscript, 7–8 and 21–22 https://barrett.dyson.cornell.edu/files/papers/Basis%20Risk%20R%20and%20R%202016_2_26.pdf.

[30] The probabilities and monetary units in table 1 are stipulated. Cov(L, P) = E[LP] − E[L]E[P], and positive uncovered loss is max(L − P, 0). Correlation under X is exactly 11/15, rounded to three decimal places in the text.

more frequent payments in no-loss states offset more frequent failures to pay during loss. If the purchaser's objective is to finance recovery when severe damage occurs, equal expected payouts therefore conceal a substantial difference in protection. The conditional shortfall captures expenditure left unfunded in the very circumstances for which the programme was purchased.

That conclusion depends on the single-period assumptions. A farmer able to save a payment received in a benign season may carry it into a later disaster, and different premiums or access to credit may alter the attractiveness of either contract. Public purchasers must also consider how the alternative insurance is administered. Clarke and Wren-Lewis demonstrate how an objective index can help resolve commitment problems even though it introduces basis risk.[31] Accepting some mismatch may thus be defensible where timely, predictable payment improves on feasible indemnity or relief procedures. The purchaser must assess those alternatives against the recovery purpose and the means available to meet the remaining loss. Where a correctly calculated index leaves the trigger unmet, a challenge to the choice of trigger concerns the public decision to adopt the product, whereas a contractual claim remains available on its own terms if the insurer miscalculates the index or withholds a triggered payment.

6 SOVEREIGN INSURANCE AND THE GOVERNANCE OF EXPENDITURE

6.1 THE STATE'S INSURANCE CLAIM AND THE VICTIM'S RIGHT TO ASSISTANCE

A disaster victim in Lao PDR seeking emergency relief or help to restore a livelihood relies on article 43 of the Law on Disaster Management, which recognises rights to several forms of assistance and refers welfare provision to regulations. The content of a particular claim depends on the benefit sought and the rules governing its delivery; article 43 fixes neither a uniform monetary grant nor an individual share of the State's insurance receipts.[32] A household whose loss falls outside the sovereign policy's trigger may accordingly seek assistance under the domestic relief provisions. Conversely, payment under that policy puts money at the government's disposal without determining which households qualify for support or how competing recovery needs are to be prioritised.

Articles 45–47 establish disaster-management funds at central, provincial and district levels, with article 55(4) empowering the corresponding committees to authorise expenditure from their funds. The Ministry of Labour and Social Welfare administers and coordinates disaster-management functions under article 59, including the receipt and consideration of requests, within the law's reporting and inspection framework.[33] A challenge to expenditure from a statutory fund can therefore be directed to the committee exercising that fund-specific power. If insurance proceeds are held under separate project financing, the claimant needs the instrument governing that money and the delegation under which it is spent. The identity of the finance ministry as policyholder alone cannot resolve a dispute over another body's refusal to approve a recovery activity.

World Bank implementation records describe Lao PDR's cover through the Southeast Asia Disaster Risk Insurance Facility (SEADRIF) as running from 1 May 2025 to 30 April 2027, with an annual limit of US$8 million and maximum cover of US$16 million. The Bank recorded premium payment and policy activation on 30 July 2025. Following severe flooding, the Ministry of Finance received US$2 million on 1 September; SEADRIF reported initiating the payment within six business days of receiving the latest national impact data, which determine the payout through cumulative official counts of disaster-affected people.[34]

The World Bank's letter agreement makes withdrawals for premiums conditional on satisfactory updating of the government's contingency plan, requires the risk-transfer agreement to incorporate compliance with that plan, and provides for an accessible project grievance mechanism.[35] The Government consequently owes the Bank obligations extending beyond the purchase of cover. An affected person's claim for assistance, however, derives from domestic law or the conditions governing the benefit sought, so a complaint through the project mechanism must be connected to the power capable of securing relief. A procedure that receives a grievance can identify a stalled transfer or disputed allocation; whether its decision-maker can order payment or revise the allocation depends on the authority conferred on that office.

6.2 FROM TREASURY RECEIPT TO RECOVERY EXPENDITURE

By October 2026, the World Bank recorded approximately 65 per cent of the September 2025 payout as disbursed, with payments made for 15 of 39 approved activities across five provinces. Its report also recorded two further sovereign receipts of

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[31] Clarke and Wren-Lewis (n 3) 19–20.

[32] Law on Disaster Management No 71/NA (24 June 2019), art 43, original Lao text, 12 https://laoofficialgazette.gov.la/kcfinder/upload/files/71%E0%BA%AA%E0%BA%9E%E0%BA%8A2019.pdf; unofficial English translation (2020), 16 https://www.refworld.org/sites/default/files/2026-06/lao-dm-law-2020-eng-v2.pdf.

[33] Law on Disaster Management (n 32), arts 17, 45–47, 55(4), 55(11), 59(2), 59(6), 59(10)–(13), 59(15) and 63–65; unofficial translation 7, 17–18, 23–24, 27–28 and 31–32.

[34] SEADRIF Insurance Company, 'Lao PDR and SEADRIF Sign Sovereign Disaster Insurance with World First Reported Impact Trigger' (18 July 2025) https://seadrif.org/news/lao-pdr-and-seadrif-sign-sovereign-disaster-insurance-with-world-s-first-reported-impact-trigger/; SEADRIF, 'SEADRIF's New Policy Delivers US$2M Payout to Lao PDR in 6 Days, Using Official National Impact Data' (3 September 2025) https://seadrif.org/news/seadrif-insurance-company-makes-payout-of-us2-million-to-support-lao-pdr-government/; World Bank, *Lao PDR: Improved Access to Disaster Risk Financing (P505224), Implementation Status and Results Report*, seq 1, ISR05376 (7 October 2025) 1 https://documents1.worldbank.org/curated/en/099100725062515855/pdf/P505224-9cb635da-1ddd-47a0-855e-1609b65b91b9.pdf; World Bank, *Implementation Support Mission, 11–14 August 2026, Aide-Memoire*, para 3, 1.

[35] International Bank for Reconstruction and Development/International Development Association and Lao PDR, *Improved Access to Disaster Risk Financing Project, Letter Agreement* (1 July 2025), annex ss 1.02(h), 2.04(e), 3.02(b), 4.01(c) and 5.01, 4 and 7–9 https://documents1.worldbank.org/curated/en/099070125094519322/pdf/P505224-c28bf362-d32b-4f0d-8f5f-6a7a86daa942.pdf.

US$1 million each on 1 and 4 September 2026.[36] These figures concern the progress of expenditure against approved activities. Determining why a particular activity remained unpaid requires the approval and procurement records, together with the timetable under which implementing officials were working. The August implementation mission identified staffing shortages and procurement difficulties, recommended stronger reporting by disaster committees and observed that the Ministry of Finance did not select the activities financed by the payout.[37] A person contesting the choice of recovery projects therefore needs a response from the selecting committee, although the Ministry remains the appropriate institution to address when the disputed step is a transfer within its authority.

The Ministry's published contingency plan distinguishes these functions. In the stakeholder-consultation draft dated 18 June 2025, disaster-management committees select activities and approve expenditure, the Ministry of Finance undertakes transfer and accounting functions, and general complaints pass through Ministry of Labour and Social Welfare staff to the central committee's steering structure.[38] Since the published text remains a consultation draft, a challenge relying on its procedures requires confirmation against the accepted plan and the formal delegations governing the expenditure. Publication of those instruments would enable disaster victims to identify the office responsible for a refusal or delay, while allowing officials to distinguish a challenge to an approved priority from a request to carry out an authorisation already given.

The Philippine catastrophe-insurance pilot shows how a disagreement over allocation can obstruct the use of promptly paid insurance. After Typhoon Tembin, modelled losses triggered a payout exceeding observed damage in Davao del Sur, and officials disagreed over distribution, including possible use beyond the triggering province and towards future premiums. Their failure to complete the allocation report required for a Notice of Cash Allocation left the proceeds at the Bureau of the Treasury, although the insurer had met its contractual timetable. The second year of the pilot introduced revised allocation and reporting procedures.[39] Governments purchasing sovereign cover need to settle how such discrepancies are to be handled before they arise: a trigger may properly release money even though the geographical distribution of observed need differs from the model. The body authorised to resolve that discrepancy must be able to approve expenditure under the applicable budget rules if the purchased liquidity is to finance recovery promptly.

7 A PUBLIC DUTY TO JUSTIFY RETAINED EXPOSURE

7.1 PUBLIC POWER AND INSTITUTIONAL COMPETENCE

An authority that uses compulsory contributions, premium subsidies or sovereign finance to pursue a protective purpose also determines which losses must be met elsewhere. Beneficiaries may learn from a policy that a treatment is excluded or a rainfall threshold has not been crossed, yet the policy says little about the public choice to finance those terms, the alternatives rejected or the complementary assistance assumed to exist. That informational asymmetry is particularly pronounced when the State receives the insurance payment and several agencies control its expenditure. The beneficiary cannot assess the exercise of public power simply by establishing that the insurer has performed its promise.

The case for a duty of justification rests on that public responsibility. I propose an express domestic obligation requiring the authority responsible for selecting publicly financed or mandated protection, or allocating its proceeds, to justify the exposure left with intended beneficiaries. Legislation, or binding rules made under sufficient statutory authority, must identify the decisions covered and assign review to a body with jurisdiction over them. Existing procedures can carry the obligation where their powers suffice, but a claims officer authorised only to calculate an indemnity cannot reconsider the government's subsidy policy. The design of the remedy is therefore a question of institutional competence, involving both the authority that selected the protection and the reviewer empowered to require a fresh decision.

The authority's procurement file preserves the evidence available when it chose the coverage, allowing a reviewer to test the grounds offered after a loss against the appraisal that informed the original decision. At renewal, later evidence becomes part of the justification for continuing the product, as distinct from the reasons for purchasing it in the first place. Table 2 sets out the powers and entitlements through which the different complaints arise.

Table 2. Institutions controlling protection and the applicable legal tests

Setting	Finance and recipient	Controlling power or legal test
Singapore health cover	Statutory premiums and subsidies fund MediShield Life, and private premiums finance supplementary cover.	The CPF Board administers statutory membership and benefits; the supplementary contract governs private admission, renewal and reinstatement.

[36] World Bank, *Implementation Status and Results Report*, ISR08961 (n 1) 1–2 and 5.

[37] World Bank, *Lao PDR: Improved Access to Disaster Risk Financing (RETF, P505224), Implementation Support Mission, 11–14 August 2026, Aide-Memoire*, paras 4–5, 8 and 10–11, 2–3 https://documents1.worldbank.org/curated/en/099093026221524702/pdf/P505224-557bcece-1f62-41fd-bbdc-158513af5d4d.pdf.

[38] Lao PDR, *Contingency Plan for the Recipient-Executed Trust Fund, Improved Access to Disaster Risk Financing Project (P505224)* (draft for stakeholder consultation, 18 June 2025), ss 2.4, 2.8, 3.4 and 3.8.2(A), 23–25, 32–33 and 40–41 https://www.mof.gov.la/storage/document/1752221146_4_%E0%BB%81%E0%BA%9C%E0%BA%99%E0%BA%AA%E0%BA%B8%E0%BA%81%E0%BB%80%E0%BA%AA%E0%BA%B5%E0%BA%99%E0%BA%82%E0%BA%AD%E0%BA%87%20%E0%BA%AA%E0%BA%9B%E0%BA%9B%20%E0%BA%A5%E0%BA%B2%E0%BA%A7%20%28LCP%29.pdf.

[39] World Bank, *The Philippines Parametric Catastrophe Risk Insurance Program Pilot: Lessons Learned* (evaluation report, December 2020; published 2021) 37–40 and 75 https://documents1.worldbank.org/curated/en/600081624863743116/pdf/The-Philippines-Parametric-Catastrophe-Risk-Insurance-Program-Pilot-Lessons-Learned.pdf.

Setting	Finance and recipient	Controlling power or legal test
Philippine HMO underwriting	An individual or group applicant seeks privately financed health cover.	The HMO's grounds for postponement or refusal are subject to Republic Act No 11166 and Insurance Commission supervision.
PCIC crop insurance	Public premium support and applicable contributions finance indemnities to insured producers.	The Board exercises powers over products and premiums, subject to the charter's approval conditions. Regional claims decisions proceed through the statutory hierarchy, including deemed approval after 60 days of inaction following complete documentation.
Malaysian consumer insurance	Premium-paying policyholders claim contractual benefits.	Part 3, Division 2 of Schedule 9 to the Financial Services Act 2013 links remedies for qualifying consumer misrepresentation to historical underwriting. Paragraph 13 separately restricts avoidance of life policies in force for more than two years, subject to material fraud.
Lao sovereign disaster cover	Donor-supported premiums finance payments to the Ministry of Finance; victims claim domestic relief.	Committees select recovery activities, with Ministry transfers and expenditure governed by the applicable fund or project instruments. Article 43 provides the domestic basis for assistance claims.

7.2 REASONS, RECORDS AND REMEDIES

Under the proposed duty, the adopting authority publishes reasons connecting the main coverage boundaries to the programme's protective purpose and available funding. A ceiling chosen to keep premiums within a fixed budget warrants a different justification from an exclusion adopted because reliable claims data are unavailable. If officials assume that households can meet a deductible from savings, their reasons need evidence of that capacity; reliance on another assistance programme requires attention to its eligibility conditions and delivery timetable. For severe-loss protection, the authority's appraisal covers the likelihood and timing of payment during the events it intends to insure, including uncertainty in those estimates. This makes the decision open to scrutiny by a beneficiary whose objection is that the public purchaser has misunderstood how the retained expenditure can be financed. Domestic enactment gives practical effect to the International Labour Organization's recommendations on defined guarantees, complaint procedures and monitoring.[40]

An authority renewing a programme can use its existing reasons where performance continues to support them, provided it records changes affecting the original assessment. Repeated failures to reach the intended beneficiaries demand a fresh decision on the accumulated evidence. Individual refusals require reasons directed to the actual dispute: a farmer contesting the date of complete documentation needs the receipt record, whereas an applicant alleging prohibited discrimination may need supervisory examination of an underwriting file. Public authorities can secure the necessary records through programme rules and procurement terms, with confidential production to the reviewer when the evidence contains personal information or commercially sensitive models. Such safeguards permit scrutiny of the decisive grounds while limiting disclosure to what the dispute requires.

The enabling instrument also sets response periods, with urgent procedures where delay threatens treatment or livelihood recovery. Ordinarily, a failure to give adequate reasons warrants disclosure of the missing grounds or reconsideration by the authorised decision-maker. A reviewer returning a defective allocation to the disaster committee leaves the expenditure decision with the institution entrusted to make it; substitution of a different allocation requires a corresponding grant of remedial power. Payment orders rest on accrued benefits, and damages depend on the applicable substantive and remedial law. A claimant can thus enforce an unpaid indemnity while separately seeking reconsideration of a ceiling that leaves additional losses uncovered, with each request determined under the legal authority governing it.

7.3 ADMINISTRATIVE BURDEN, ADVERSE SELECTION AND OUTCOMES

Requiring elaborate reasons for every routine determination could consume the capacity needed to settle claims. Participating insurers may also recover the cost of additional retention and disclosure obligations through their premiums. The proposed duty should consequently use procurement files and actuarial assessments already generated at programme design, reserving individual investigation for contested grounds or departures from the published rules. During an emergency, officials need authority to release urgent assistance before completing the written reasons, subject to prompt recording afterwards. Without an accessible route to timely correction, officials could satisfy the reporting requirement while leaving a mistaken refusal undisturbed.

Rothschild and Stiglitz's analysis of adverse selection shows how an insurer competing for lower risks can undermine a pooling contract when information is asymmetric.[41] For a public authority maintaining broad admission at pooled rates, sustainable contributions and transfers form part of the coverage decision, together with the terms on which private insurers participate. Preserving a chronically ill policyholder's renewal rights through temporary premium assistance may avert a lasting loss of cover, but the subsidy consumes resources that could support other beneficiaries. Likewise, a crop programme offering modest insured amounts to many farmers accepts a greater shortfall for those suffering the most severe damage. The

[40] ILO Recommendation No 202 (n 4), paras 7–9 and 19–21, 133–134.

[41] Michael Rothschild and Joseph Stiglitz, 'Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information' (1976) 90(4) *Quarterly Journal of Economics* 629, 632–637 https://doi.org/10.2307/1885326.

distribution between those beneficiaries remains a public choice even when every claim is settled correctly, and the authority's budget and statutory purpose determine the grounds on which it can be defended.

In its report on disaster-risk financing, the ASEAN Secretariat documents differences in national instruments and administrative development that bear directly on the feasibility of insurance, reserves and contingent finance.[42] For the finance ministry, the cost of obtaining liquidity has to be considered together with its capacity to spend it. Buying a more responsive trigger achieves little for a recovery project held up by an unresolved allocation rule, just as a theoretically generous indemnity may be of limited use to a farmer who cannot finance planting before settlement.

Outcome monitoring should therefore follow the expenditure or service the programme was established to secure. Claims systems need to record when an approved sum was paid, so administrators can distinguish delay in determining liability from a failure to release money already due. For sovereign insurance, the ministry's transfer to an implementing agency remains an intermediate event, followed by procurement and delivery. If successive reports show that an approved recovery activity remains unfunded, the responsible officials need to identify whether the obstacle lies in allocation, transfer or implementation. Under the proposed duty, renewing the same programme then requires a reasoned response to that evidence, including reconsideration of the rule or procedure responsible for the repeated failure.

8 CONCLUSION

Publicly supported insurance distributes responsibility across decisions that confer different rights and permit different remedies. An insurer's payment may satisfy the policy even though a beneficiary still lacks the resources required for recovery; a lawful coverage limit may leave the public purchaser's choice open to challenge under the powers governing the programme. Where a benefit has already accrued, however, the claimant can pursue performance of that obligation. Residual loss provides a basis for connecting these inquiries because it keeps the beneficiary's unmet need in view as responsibility passes between private underwriting and public administration.

The proposed duty makes the authority answer for the exposure it has chosen to retain. Beneficiaries cannot reconstruct that choice from a policy exclusion or an announcement that the sovereign insurer has paid. They need access to the grounds on which public funds were committed and to the institution authorised to reconsider the disputed rule or allocation. The required evidence depends on the claim: a historical underwriting counterfactual, an allegation that a prohibited ground influenced refusal, and a challenge to public product selection each demand a different use of decision records. A carefully framed duty can support those inquiries while leaving payment and damages dependent on the substantive rights governing the dispute.

Equal expected insurance payments can conceal large differences in severe-loss exposure, and rapid sovereign payment can precede a lengthy domestic expenditure process. The proposed duty should therefore connect reasons and decision records to review of the protection actually delivered. Where delay threatens medical treatment or livelihood recovery, that review must be capable of securing timely reconsideration by the authority with power to act, alongside enforcement of benefits already due.

[42] ASEAN Secretariat, *Disaster Risk Financing and Insurance in Southeast Asia: Trends, Challenges, and Strategic Approaches* (ASEAN Socio-Cultural Community Trend Report No 12, 2025) viii, 9–11 and 18 https://asean.org/wp-content/uploads/2025/04/20240401_Trend-Report_DM-12-2025.pdf.