भारतीय बीमा संस्थान
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INSUNEWS

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QUOTE OF THE WEEK

"Vision without action is merely a dream. Action without vision just passes the time. Vision with action can change the world."

Joel A. Barker

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

OPD cover

Out patient department (OPD) cover is offered as part of health insurance policies.

OPD treatment refers to procedures that do not require a stay in the hospital and are done in the out-patient department.

Apollo Munich and Max Bupa offer cashless OPD facility. However, there are limits to how much of the expense will be covered under OPD in a year. Max Bupa's Go Active family floater plan offers 10 cashless or reimbursable consultations with a cap of ₹500-600 per consultation. However, compare the policies with and without OPD covers on premium terms to see if they are actually cost-effective.

Source

INSURANCE REGULATION

How do we regulate insurance innovations? - The Hindu Business Line – 28th May 2019

The Insurance Regulatory and Development Authority of India (IRDA) recently released draft regulations for regulatory sandbox (in simple terms, live testing of financial innovations for regulatory compliance) for the insurance sector in India.

The regulations are based on a report released in February this year by the regulator, and seek to lay down principles based on which innovative insurance firms can be allowed to develop products in a relaxed regulatory environment.

However, apart from lacking on several critical fronts, the regulations have been put out in the public domain for comments, for exactly 13 days, critically placed at a time when the country's national election results were being announced, and in any case a time period too short for any serious analysis and scrutiny. The regulations themselves scriimp on important issues of customer protection. To start with, they speak to customer protection at exactly one place, the 'objective'. There is no explicit provision detailing the liability frameworks that would hold an applicant entity accountable for ensuring customer protection, or on compensation measures.

On data protection, the draft regulations provide very little clarity. The regulations simply mandate the maintenance of confidentiality of customer data, and an eventual deletion of all personal data of customers, without prescribing any other measures for data protection, and prevention of exploitation of such data by entities.

The regulations painfully confuse 'confidentiality' of customer data with data protection. Unlike the report released by the regulator earlier which put the onus of policyholder data protection on the applicant entity — data preservation, confidentiality, integrity and availability of the same, irrespective of whether the data is stored/in transit within themselves or with customers or with the third party vendors; the regulations provide for nothing.

The regulations also do not mandate express customer consent — to buy the policy or be given information about the potential risks; a critical aspect of data protection, and affording customers agency.

In fact, the regulations fail to provide policyholders with an option to opt out of the policy post the proposal stage, something that was emphasised in the February report.

Consumer unprotected

Most critically, the regulations have no provisions on preventing applicant entities from selling policies to un-nuanced and vulnerable financial customers. With no concrete liability or compensation framework, negligible emphasis on data protection, and no overarching law on financial customer protection in India, these regulations lack serious oversight, and offer little credibility.

Further, the regulations do not mandate firms to develop, and inform the regulator and customers about risk mitigation strategies. This is in sharp contrast to regulations released by other countries. For instance, Singapore's consultation paper on the creation of pre-defined sandboxes, known as Sandbox Express, expressly stated that this leeway was suitable for activities where the risks are generally low.

A reading of the guidelines mentioned in the consultation paper revealed that to safeguard the interests of the entity's customers and contain potential risks of the experiment, a number of procedures were required to be followed by the applicant entity like providing clear and proper disclosure to every user and obtain an acknowledgement before the user can be on-boarded as its customer; limiting the customer base to only institutional and accredited investors who are not individuals; maintaining records of all transactions; disbarring the handling or holding of customer's monies, ensuring the fitness and propriety of the firm's shareholders, chief executive officer, directors and broking staff; and putting in place internal controls and processes to mitigate risks associated with the experiment, like money laundering and terrorism financing risks and technology risks such as cyber attacks.

It also seems counter-intuitive to have multiple regulators release their own guidelines on the same issue of technology and innovation (the RBI came out with its draft framework for fintech firms last month) particularly when the issues facing them are essentially the same — how best to protect financial consumers, while promoting financial innovation.

In such a scenario, it might be better to establish a common council or forum, with representation from all the financial sector regulators, to create a harmonised regulatory environment. In Washington DC for instance, the Mayor established a 'Financial Services Regulatory Sandbox and Innovation Council', chaired by a Commissioner for the Department of Insurance, Securities and Banking.

This not only ensures the evolution of a common regulatory framework for innovation hubs and regulatory sandboxes for all fintech firms looking to innovate and grow, but also creates a level playing field, capitalising on regulatory foresight and the development of best practices. In fact, the recent joint report of the European Supervisory Authorities reveals that in an analysis of the regulatory sandboxes established across Europe, it was clear that they are not limited to a specific part of the financial sector but are cross-sectoral (e.g. banking, investment activities and services, and insurance) in the kind of work they do.

In Hong Kong, the Fintech Supervisory Sandbox launched in 2016 has now been upgraded, to provide feedback to entities at an early stage of their fintech projects, and the sandboxes run by the other Hong Kong regulators like the securities regulator and the Insurance Authority have been linked, to provide a single point of entry for pilot trials of cross-sector fintech products.

With the IRDA and the RBI both releasing draft frameworks for fintech firms, coupled with growing consciousness over data privacy and customer protection, we need a holistic approach to financial sector innovations. A harmonised approach to data privacy and customer protection, both in the regulatory sandbox space and outside of it will enable a deeper understanding of operating principles for fintech innovation and risks, cross-sectoral innovation, and regulatory co-ordination. Without a uniform and rigorous approach to issues to technology, the most likely to suffer will be the most disenfranchised amongst us, and innovation will be limited to pockets of convenience and privilege.

(The writer is Shohini Sengupta is policy lawyer based in Delhi.)

TOP

Source

LIFE INSURANCE

Life insurance: Know how a joint life cover works – Financial Express – 31st May 2019

Life insurance is all about protecting and supporting your loved ones. It gives you great peace of mind when you know that your family will be financially secure in the event of your sudden death. The money that your dependents receive can be used for household bills, daily expenses, children's education and marriage, and healthcare. The total sum insured needed greatly varies from person to person as everyone has their individual needs and requirements.

In the last couple of years, there has been a significant rise in the number of working couples. This has forced people to realise the need of life insurance cover for the spouse as well. No doubt, it seems a sensible option as both the partners have provisions in place to provide a financial safety net for their family in the event of their premature death. At the same time, many individuals es who have a non-working spouse think of investing in a joint life cover as they wish to secure the life of their partner. Buying a joint life cover for a non-working spouse assures that the person does not have to depend upon anyone for financial help. A joint life cover gives financial stability to both the lives insured.

Joint life cover

As the name suggests, a joint life insurance policy covers two individuals often on a 'first death' basis meaning the total sum insured is paid out if either of them dies during the length of the policy. However, most policies end immediately after the death of any one of the insured members.

The need for a joint life cover

The need for joint life cover came into existence with the introduction of double income nuclear families in the society. In such families, both the earning members, i.e., husband and wife, contribute equally towards meeting the various household expenses including lifestyle, loans, kids' education, marriage and a lot more. Considering all these aspects, the financial impact of death or disability of any of the earning members is very big and it is very important that all such unforeseen events must be adequately covered by investing in a joint life cover.

Joint life cover is best for young couples, especially those who have dependent children. The sum assured that the partner receives on death of the spouse is quite significant. One may even choose to cover the life of the non-working spouse as well as in case of death of the breadwinner, taking care of the dependent children and other family members can be a challenging task without an appropriate financial support.

Advantages

The main advantage of a joint life insurance policy is that it is relatively cheaper than buying two individual insurance plans. For people on a budget and looking to get a joint policy, this may be a good option. Joint policies often appeal to couples who don't have children as dependents and only count each other as their main dependents. In case of some joint life insurance policies, there is a payment on the death of each of the two individuals. Under all such plans, the insurer provides a regular income to the surviving spouse for a fixed time period which is usually up to 60 months. The amount paid in monthly instalments is usually in addition to the death benefit paid to the surviving spouse. Under a joint life insurance cover, you can easily add critical illness rider to the base policy. The premiums paid are eligible for tax benefits under Sections 80C and 10(10D).

(The writer Santosh Agarwal is chief business officer, Life Insurance, Policybazaar.com)

TOP

Source

Can NRIs purchase life insurance in India? Find out – Financial Express – 27th April 2019

If you are an NRI and are thinking of buying a life insurance plan in India, then definitely you are taking a wise call. Especially, when you are away from your native land and have dependents to look after (who are residing in India), buying a life insurance policy seems to be a perfect decision. But the question is: "Is it possible for NRIs to purchase a life insurance plan in India"?

The answer to this question is YES, it is possible for NRIs to buy a life insurance policy in India and protect their and their family's life. As per FEMA, individuals who are residents of foreign countries, as well as Persons of Indian Origin (may or may not be the citizens of India), are permitted to buy insurance in India.

As you scroll down, you would get more information about the process of buying life insurance in India being an NRI:

Availability of policy seeker in India
An NRI need not be present while buying the policy; he or she can purchase the policy from his or her current resident country either through online mode or by communicating via written communication with the insurer.

Eligibility
If an NRI wishes to buy life insurance in India, he or she should have a valid passport issued by the Government of India. And if you are a Person of Indian Origin or overseas citizen of India, then you should either have an Indian passport anytime in the past, or either you or your parents or grandparents should be an Indian citizen by virtue of the Constitution of India or the Citizenship Act, 1955, or you should be a spouse to a citizen of India or a person referred in clauses 1 or 2.

Cost of premiums
Generally, the costs of premiums are similar for both the residents as well as non-residents. However, the premium of the policy might differ depending on the applicant's country of residence, i.e. the premiums would be high for high-risk countries while premiums would be low for low-risk countries.

Note: High-risk countries are those countries which are more prone to civil or military issues, are run by an unstable government and face constant violent attacks. On the other hand, low-risk countries are those countries which are usually peaceful and are run by a stable government along with proper law and order.

Mode of payment of premiums
The modes of payment of premiums are classified into two categories:
Paying the premiums in rupees using NRO accounts (for rupee denominated policies).
Paying in foreign currency or through NRE/FCNR account (for foreign currency denominated policies).

Know the tax laws of your country
In India, the current tax laws exempt all the three stages of the policy life cycle from tax; however, it is very significant for the applicant to understand the tax laws for both India and the resident country before opting for an insurance policy in India.

Medical Examination Procedure
There are two ways in which the medical examination procedure could be conducted:

Either you fly down to India, wherein the expenses would be borne by your insurer, or

You can do the medical examination at your resident country and send the reports to the insurer in India. However, in this case, you would have to bear the cost unless you have opted for a policy which is targeted specifically for non-residents.

Piece of advice

Opting for life insurance would not only help you but will provide financial aid to your family in your absence. Moreover, buying a policy as an NRI is like ensuring your loved ones in your native land and be tension free especially when you are away from them.

(By, Rakesh Goyal, Director, Probus Insurance)

TOP

Source

Protection pays - The Hindu Business Line – 26th May 2019

Sharp focus on the protection business to drive growth and improve profitability, better customer engagement, attention to cost efficiencies and improving persistency were the key highlights of life insurance players' March quarter earnings, as it was for the full fiscal of 2019.

Given the challenges in the savings business, life insurance players have been focussing on the protection business. Savings products comprise linked, participating and non-participating policies. Protection products provide cover for life, disability, critical illness and accidental death. These pure risk protection products are low-cost.

By focusing on protection business, life insurance players have been driving value of new business (VNB). Since premium payments for life insurance policies are spread over time, the cost of new customer acquisition is high, leading to new business strain. VNB is a key measure to assess the financial performance of insurers. It values future profit streams of the new business written during the year.

Pick-up in growth

After a muted performance in the nine months ended December 2018, ICICI Prudential Life Insurance saw some pick-up in growth. Annualised premium equivalent or APE grew by 11 per cent Y-o-Y in the March quarter, after declining by 4.2 per cent in the nine months ended December 2018. Overall for FY19, APE was flat (0.1 per cent growth). The growth in APE in FY19 has been led by strong focus on the protection business. Protection APE grew by 61.9 per cent in FY19, constituting 9.3 per cent of APE, up from 5.7 per cent in FY18.

However, despite the increase in share of protection business, savings business (90.7 per cent) remains a significant part of ICICI Pru Life's APE. Within savings, unit linked products (ULIPs) account for a tidy 79.6 per cent of APE in FY19 (slightly down from 81.9 per cent in FY18).

ICICI Pru Life, through its focus on protection business, believes that it can sustain profitability. Currently, VNB from protection business is about 60 per cent of the overall VNB. In FY19, ICICI Pru Life witnessed a marginal 3.3 per cent growth in VNB.

VNB margin — the ratio of VNB to APE — went up by 50 bps to 17 per cent in FY19. While favourable business mix mainly on account of protection-led growth helped, higher acquisition cost weighed on the margins. The management expects to double VNB over the next three to four years.

Improved persistency

Aside from ramping up premium growth, the company was also focused on improving persistency, which measures the number of policies (or in terms of premium) retained with an insurer across different time periods.

After some decline as of December 2018, ICICI Pru Life's 13th month persistency (second year) improved to 86.1 per cent (from 84 per cent for eight months of FY19). However, it more or less remained flat from levels of FY18 (85.8 per cent). The profit-after-tax for FY19 was ₹1,141 crore as compared to ₹1,620 crore in FY18. The drop in profit is led by increase in new business strain due to strong growth in protection and annuity segment.

Leveraging on its brand and distribution network, SBI Life posted a robust set of numbers, with new business premium growing by 26 per cent in FY19, above-industry (private players) growth of 22 per cent. Ranking number one in terms of individual rated premium, SBI Life has a market share of 22.3 per cent among private players. Increased focus on protection business led to the share of protection APE inching up to 6.8 per cent in FY19 from 5.4 per cent in FY18.

This helped VNB increase by 24 per cent Y-o-Y in FY19 to ₹1,720 crore; VNB margin expanded by 150 basis points. SBI Life's profit-after-tax grew by 15 per cent Y-o-Y in FY19 to ₹1,330 crore. SBI Life has a well-diversified product portfolio with savings forming 88 per cent of new business premium; ULIPs form about 53 per cent.

Apart from strong financial metrics, other operating metrics such as persistency and expense ratio also continued to improve in FY19. SBI Life's 13th month persistency improved to 85 per cent in FY19 from 83 per cent in FY18. Operating expense ratio declined to 6.4 per cent from 6.8 per cent in the previous year.

For HDFC Life, its resilient earnings, strong leadership position, and well-balanced product mix have always been a key positive. In FY19, HDFC Life's overall APE grew by 13 per cent while new business premium reported a robust growth of 32 per cent Y-o-Y.

Share of protection business moved up to 16.7 per cent of overall APE from 11.3 per cent in FY18. While VNB grew by 20 per cent Y-o-Y to ₹1,540 crore in FY19, VNB margins moved up by 140 bps to 24.6 per cent. HDFC Life's share of ULIP came down as the company focussed on ramping up its protection business. The insurer's 13th month persistency remained healthy at 87 per cent in FY19.

(The writer is Radhika Merwin.)

TOP

Source

How traditional life insurance plans tend to weigh you down – Mint – 25th May 2019

"Traditional plans have the largest share in product mix of life insurance industry," said Aalok Bhan, director and chief marketing officer, Max Life Insurance. The life insurance behemoth, Life Insurance Corporation Ltd., has a product portfolio that is tilted towards traditional products. Around 86% of LIC plans are traditional products (excluding riders). "Traditional plans are designed to help build a corpus over a long term for the achievement of a life's goals and suitable for those who have low investment risk appetite," said Bhan. Let's take a look at if such long tenures helpful:

UNSUITED DEMOGRAPHY

The long tenure, combined with strict lock-in periods of traditional products and inadequate cover do not fall in line with the demographics of our country and tend to weigh us down. Traditional products have a lock-in period of at least three years. "You can't withdraw the money in the first three years. After that, the only way you can get some liquidity is by taking a loan on the surrender value or surrendering the policy," said Agrawal. The demographic profile of India in terms of savings and investment is at par across income profiles. "Whether you're from a middle-income category or an HNI, it has been widely

observed that Indians feel the need for liquid cash three to five years after parking their corpus in an investment," said Pawan Agrawal, founder of Investguru.in. Also, there are multiple other financial instruments you can evaluate it with before investing.

LOAN, SURRENDER VALUE

Say you've already invested a huge corpus in a traditional product and you come across an emergency. Your agent will try to lure you into taking a loan on your surrender value, where the loan amount is capped at 90% of the surrender value. "The interest you receive from the plan is lesser than the interest you end up paying to the insurer on the loan," said Agrawal. If you want to surrender the policy mid-way, you will lose money. The product structure is such that it ends up benefiting the insurer . "After three years of payment, the policy gains a surrender value. If you need the money, the policy can be surrendered, but in the first 7-9 year period, the surrender value is lesser than original capital," he said.

PUSH PRODUCTS, PREMIUM DEFAULTS, COMPOUNDING

Time and again, traditional life insurance products have been viewed as a push product. By 'push' product we mean the agents and insurers push the product on you for sale at times, without keeping your financial goals and interests in mind. "Large portion of your premium gets paid out as commission to the agents," said Vishal Dhawan, founder of Plan Ahead Wealth Advisors. "If you don't pay at least three years' premium, your policy lapses and whatever you have paid gets lost. If you pay three years' premium and you do not pay after that, the policy lapses and becomes paid up, meaning the benefits get reduced and you can get that value only when policy term is over. This amount in the first 7-8 years doesn't cover your original capital," said Agrawal. Traditional products that are popular are those which have a money-back guarantee. Money-back plans give you some amount of money annually from the capital. "Due to this, the power of compounding reduces," said Dhawan. The instruments traditional plans invest in don't earn higher returns as well.

WHAT YOU SHOULD DO

Such products are a tad bit beneficial only when you hold the product for at least 15 to 20 years. "If you wait for the whole term to get over, only then will your capital cost get covered and at the end whatever you receive may be higher than the invested capital," said Agrawal. But, does your opportunity cost get covered? It's the cost of the missed opportunity you got had you invested somewhere else. "Over a 20-year period, a traditional life insurance policy gives returns of 4-6%, tax-free. If we compare this with RD returns for higher tax brackets, there may not be much difference. But, if we compare it to balanced or equity based funds, opportunity cost is huge. In a traditional policy, if you pay ₹5,000/year for 20 years, you get around ₹1.8-2 lakh as maturity value; if you invest the same in mutual fund, at 10% return, you get ₹2.86 lakh; at 12% you get ₹3.6 lakh and so on," he said. Make sure you evaluate your cover before buying.

(The writer is Revati Krishna.)

TOP

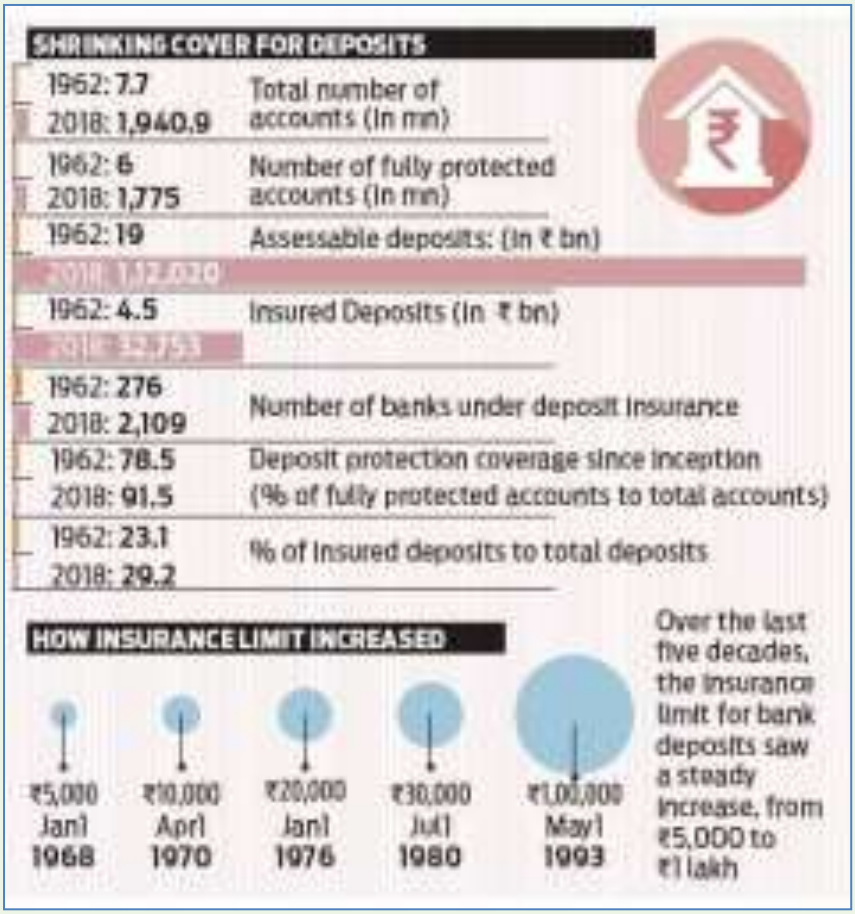
Source

GENERAL INSURANCE

Insurance cover for bank deposits falls to 30 per cent - The New Indian Express – 30th May 2019

Banks may be worried about slowing deposits growth, but it's the depositors who should be paying attention. Insurance cover for bank deposits fell to 30 per cent as on March 2018, from a mighty 76 per cent in March 1996. Just a decade ago, it stood at a respectable 60 per cent, but has been steadily declining

Interestingly, over 90 per cent of all bank accounts are covered under the Deposit Insurance and Credit Guarantee Corporation Act (DICGC), but the downward trend is stark in terms of value as the insurance limit — currently at Rs 1 lakh per depositor per bank — was last revised 25 years ago. "There will be a large number of depositor accounts that have less than Rs 1 lakh, so the coverage in terms of accounts covered is high, but the amount as a percentage of total assessable deposits will be less. There should be a revision in insurance limit to cover a larger portion of total deposits," said Anil Gupta, Vice President, Sector Head - Financial Sector Ratings, ICRA Ratings.



In 1962, when insurance cover was introduced, the amount was limited to Rs 1,500 per depositor, but it has been revised five times since.

The last revision was done in 1993, to Rs 1 lakh, and while deposits grew, the insurance limit remained the same.

"If you look at inflation over the last 30 years, the deposit insurance amount should have been revised substantially. There should be a mechanism where the insurance amount keeps getting revised," Gupta explained.

"It should at least cover 60-70 per cent in value terms. Whether that amount comes to Rs 5 lakh or Rs 20 lakh needs to be worked out by banks," he added. While assessable deposits with insurance cover in public sector banks is over 30 per cent, worryingly, among private sector lenders this figure is nearly half at 18 per cent.

Moreover, India's coverage limits vary markedly from other countries, especially when other government guarantees are accounted for, data from the World Bank shows.For instance, while India's Rs 1 lakh cover translates to $1,613, statutory coverage limits are as high as $95,000 in Japan, $1.6 lakh in Indonesia, $2.5 lakh in the US, $15 lakh in Thailand.

Unbelievably, countries like Turkmenistan and Uzbekistan even offer blanket guarantees on deposits! Deposit insurance prevents large-scale depositor runs, while the financial safety net restores consumer confidence.

Only a few countries, such as Iceland, broke their promises on insured deposits during the 2008 financial crisis or imposed substantial losses on uninsured depositors.

(The writer is Sunitha natti.)

Source

TOP

Power producers cry foul over high insurance costs - The Hindu Business Line – 29th May 2019

A three times increase in the cost of insuring power projects has irked thermal power generation companies. The higher cost of insurance is being attributed to a February circular by the General Insurance Corporation of India (GIC).

In a letter written last week to the Ministry of Power, the Association of Power Producers (APP) said, "Due to the new GIC Re circular, the insurance premiums for power plants, say of 1,000-MW unit size, have significantly increased…The increase has been over 200 per cent which is against the basic principle of insurance."

GIC Re is the country's largest reinsurer. It has a treaty with insurance companies that allows the pooling of capital by various reinsurers to provide reinsurance support. The February circular said the insurers who want to get the benefit of the treaty will have to quote higher premium rates from March 1 for providing cover to companies in eight sectors that report higher claims.

These are manufacturing rubber goods, plastics, textiles, chemical manufacturing below 32 degrees centigrade flashpoint, transporters' godowns, steel plants and thermal power plants. According to the APP, the premium for insuring a 1,000 MW power plant for an assured sum of ₹6,000 crore was ₹2.60 crore in 2018-2019. This has now increased 199 per cent to ₹7.77 crore.

"This sum assured includes huge coverage of high severity and low frequency outcomes such as Fire Loss of Profit (FLOP) and Machinery Loss of Profit (MLOP). It is important to note that premium for such losses which are catastrophic in nature and low probability of occurrence needs to be smoothened over a period of 10-15 years rather than being levied abruptly for a sector that is strained already. A gradual increase of 30-40 per cent over a 5-year period may be more reasonable and easily acceptable," the association said.

There is also a 'drastic' revision in the deductibles, according to the APP. "The material damage deductible has increased 150 per cent from ₹50 lakh to ₹1.25 crore. The business interruption deductible would be ₹100 crore in 2019 from ₹42 crore in 2018 for a 1,000 MW plant (considering ₹1,200 crore of FLOP) in the event of a natural calamity like cyclone as there would be a waiting period of 30 days before the claim is considered," the APP said.

"The higher insurance costs especially affect the companies with just one or two thermal power projects as their business is dependent only on one asset. This also drives up costs of insuring machinery as the risk perception is higher in the event of an outage," a power sector official said.

(The writer is Twesh Mishra.)

TOP

Source

Save your home and car this monsoon season - The Hindu Business Line – 29th May 2019

Cyclone storms and flash floods have become very common in recent years. The damage due to Cyclone Fani has run into few thousand crores. While those who have insured their home and vehicles were saved, others faced irreparable loss.

Rather than doing a guesstimate on whether the IMD will get its prediction right on normal rains this year, sign up for insurance and secure your properties.

Car insurance

A motor insurance policy has basically two parts — an own damage (OD) cover and a third-party liability cover. While the latteris compulsory, the former is optional. Damages due to a natural catastrophe, such as a cyclone, fall under the OD cover.

From September 1, 2018, it has become mandatory for all new vehicles to have a long-term insurance cover. The owner must shell out upfront the entire premium for the third-party cover for three years at one go. The OD cover can be renewed every year.

During the Orissa floods this year, many car insurers rejected claims for repair or replacement of the engine as in most cases, it was a 'consequential loss'. This means that the owner tried to move the vehicle through a water-logged area. Consequential losses are not covered under the regular motor insurance policies, as they are not the outcome of a catastrophic event, but the result of a certain action of the policyholder. However, in case of events such as cyclones, there is no such distinction.

Say your car was was damaged because of a tree collapsing on it due tohigh winds, then it will still be covered under motor insurance. But note that accessories such as the music player, parking camera and air-conditioner are not covered under the regular motor insurance policy unless you specifically ask for it and pay an additional premium.

Car interiors and upholstery are covered, but they attract high depreciation. For all rubber, plastic and nylon parts, tyres and tubes, batteries and air bags, the insurance cover assumes 50 per cent depreciation. For fibre glass components, 30 per cent depreciation is charged. For wooden, metal and other parts, depending on the age of the vehicle, depreciation may vary from 5-50 per cent. To avoid any disappointments at the time of need, you can opt for add-on covers that come with the motor insurance policies.

You can also consider a 'zero depreciation' or 'bumper-to-bumper' cover. This is slightly expensive but pays full price for claim on spare parts. The 'invoice cover' is another add-on. Here, the policyholder will be paid the cost of buying a new car of a similar make and model. The additional premium for zero depreciation and invoice cover will be about 10-20 per cent.

Home insurance

During catastrophic events, both the exterior of the building and the contents inside can get damaged. To cover your home, you can either choose a basic fire policy or a comprehensive home insurance cover. While a fire policy may cover the house only against fire and allied perils, a comprehensive home insurance will also cover other risks, such as loss due to burglary, earthquake, fire, landslide, and flood. In case of fire policies, also note that any consequential loss will not be covered.

In a comprehensive home insurance policy again, you will have many options. If you want to cover the structure of your house, go for the 're-instatement cover' rather than an 'indemnity cover'. The former will compensate you for the cost of reconstructing the home; and the latter calculates compensation on the re-construction cost less depreciation.

In addition, make sure you buy a policy that pays up for replacing the damaged contents. If you want a cover for electrical/mechanical break-down, you should ask for it specifically; otherwise, it is generally excluded. Also, remember that DG sets and solar panels, which are usually installed outside the house, may not be covered under home insurance and one needs to specifically include these under the policy.

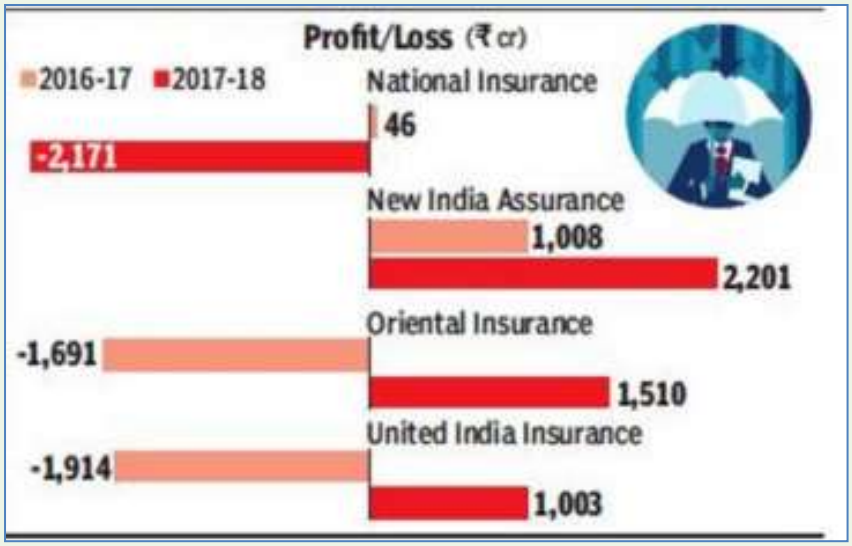
(The writer is Rajalakshmi Nirmal.)

TOP

Source

Government may use acquisition route for general insurers – The Times of India – 29th May 2019

The government is exploring the option of acquisition among the three public sector general insurance companies as part of a consolidation exercise, and a final call will be taken by the new government, sources said on Tuesday.



So far, the NDA had talked about mergers in the state-run insurance company space as it plotted a strategy to improve the financial health of these companies and raise much-needed resources for the government.

The department of investment and public asset management (Dipam) met on Tuesday to discuss the strategy for the three public sector general insurance companies.

"Various options were discussed. Whether it is going to be acquisition or merger — the decision will be taken by the new Cabinet," said an official aware of the developments.

If the government opts for acquisition by the financially strongest company among the three, it would be the third such instance after acquisition of HPCL by ONGC, the country's largest oil and gas producer, along with state-run Power Finance Corporation's (PFC's) acquisition of Rural Electrification Corporation (REC).

An acquisition of government shares in the other two entities will also help the Centre raise some funds and bolster its disinvestment corpus.

Finance minister Arun Jaitley in his 2018-19 budget speech had said that three public sector general insurance companies — National Insurance, United India Insurance and Oriental Insurance — would be merged into a single entity and subsequently listed.

The plan was part of the government's overall strategy of consolidation in the public enterprises space. Last year, Dipam had asked the department of financial services to get the issue of merger of the three companies examined and prepare a fresh road map as there was a view that rushing into a decision would not be prudent.

Latest results show that National Insurance reported a loss of over Rs 2,000 crore. Among the rest two, Oriental Insurance's profit was higher than United India Insurance's in 2017-18. But the financial health of the insurance companies has been a matter of concern, triggering talks of recapitalisation.

The government is keen to wrap up transaction involving the three companies in the current fiscal year. Officials at Dipam are looking at a timeline of October for completing the transaction.

(The writer is Surojit Gupta.)

Source

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HEALTH INSURANCE

Court quashes 91 state orders rejecting insurance claims of Tamil Nadu government employees – The Times of India – 29th May 2019

The Madras high court has pulled up the state government for rejecting reimbursement claims of government employees and pensioners under the Tamil Nadu Government Employees Health Insurance Scheme for unjustified reasons.

Justice R Suresh Kumar quashed 91 such orders, passed by district-level committees, rejecting the claim applications on flimsy, unworthy and unsustainable grounds. The committees have been directed to reconsider the applications and order reimbursement by the insurer with 6% interest.

According to the petitioners, who are either government employees, pensioners or their kin, are covered under the compulsory government insurance scheme which is notified once in four years. As per the terms of the present scheme, cashless treatment can be availed of by the members in the network hospitals. If the hospital is not in the network, reimbursement can be claimed. The state deducts the premium for the insurance directly from the employee's salary account.

The petitioners had undergone treatments in various non-network hospitals which is not permissible as per the scheme condition. Refusing to concur, Justice Suresh Kumar said, "This court wants to remind once again that courts have taken the view that it is for the medical expert to decide as to which case is an emergency one to be attended immediately and which case is not. Neither the administrators nor this court has got any expertise to decide as to whether a particular case was to be treated immediately at the given point of time or could have been postponed for some time enabling the patient to approach the network hospital and it is the matter to be solely decided only by the medical experts."

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Source

How health cover for the mentally ill works – DNA – 29th May 2019

Mental health is finally getting the attention it deserves. Insurance Regulatory Development Authority of India (Irdai) this month introduced new rules that mandate every insurance company to cover problems, including genetic diseases, mental illnesses, and menopause-related disorders. In addition, health insurance cover would also be extended to the use of drugs or anti-depressants advised by medical practitioners during the course of treatment.

While the inclusion of mental illness in health insurance coverage may wipe out the lingering disparity between physical problems and mental illnesses, mere implementation of guidelines by Irda will be of no help unless the insurance companies introduce meaningful OPD products.

The waiting period clause

Pre-existing disorders will, however, be continued to be excluded with a maximum waiting period of two years under the health insurance plans. This raises the question as to whether people with pre-existing mental health problems have to abide by the mandatory waiting period as per the policy's terms and conditions. If yes, does this contradict the purpose for which Irdai had brought forth these guidelines? Raj Khosla, founder, and managing director, MyMoneyMantra.com says, "Irda's current proposals on non-exclusion of mental health problems or age-related illnesses and exclusion of the listed pre-existing

illnesses are not contradictory. If implemented, this will be a step in the right direction, resulting in rationalisation and standardisation of the exclusions in the health insurance contract."

WIDER AMBIT
• Customers requiring hospitalisation due to menopause-related problems and neurodegenerative disorders can claim all medical expenses • The implementation of the new guidelines does not prohibit or impede the policy renewal process

With no specific guidelines concerning the waiting period, insurance companies may enjoy a free hand in deciding the same while extending health cover for both pre-existing mental health problems or those diagnosed after the policy has been bought.

Nature of cover

Health insurance plans may be bought for individual self or as family floaters to cover the entire family. Subramanyam Brahmajosyula, head - underwriting & reinsurance, SBI General Insurance, says, "As far as family floater policies are concerned, the fact that one person is suffering from, for example, mental illness does not necessarily become a reason for rejecting a family floater cover. The maximum number of members who can be covered under a family floater policy are four (self, spouse and up to two dependent children)." This means that customers can avail the benefits of individual plans or family floater policies as per their needs.

"If a proposal is accepted after due evaluation, we would not normally impose any restriction on benefits such as room rent, ICU charges, consultancy charges, etc," added Subramanyam.

Extent of cover

Depending on need, one can opt for any amount of cover. Shreeraj Deshpande (principal officer and officiating CEO), Future Generali General Insurance, says, "We have a wide range of health products offering health coverage ranging from Rs 50,000 to Rs one crore. Customers with a history of mental illnesses, menopause-related problems, and neurodegenerative disorders can choose the sum insured as per their need and we will be able to issue policies as per underwriting guidelines as well as policy terms and conditions of the particular product."

Benefits intact

Apart from the nature and extent of cover, customers choose plans based on the benefits promised to the insured. Cashless hospitalisation, No Claim Bonus (NCB) in lieu of claim-free years, etc, are features that customers look into before making their choice of plans.

Not all hospitals provide mental treatment facilities. This means that insurance companies will now have to tie up with more hospitals that include provision for treatment of mental health issues or psychiatric rehabilitation centres to avail the cashless benefits to their customers. Deshpande says, "We are already providing cashless facilities for our customers through our impanelled hospitals. Most of our network hospitals provide treatment for mental diseases also. We are always expanding our network to meet the customers' requirements and the same is done within the framework of regulatory provisions."

The implementation of the new guidelines does not prohibit or impede the policy renewal process. Shanai Ghosh, chief marketing and commercial strategy, Edelweiss General Insurance, says, "All customers can renew their policies each year, and renewal shall be offered lifelong except on grounds of misrepresentation, provided these policies are renewed in time."

Companies such as Edelweiss General Insurance had introduced added benefits including zero discharge time, guaranteed bed and zero deposit for their customers. Explaining how these benefits would be extended to mentally distraught policyholders too, Ghosh says, "These services would be available to all policyholders."

In addition, provisions, including pre- and post-hospitalisation expenses are benefits that decide the feasibility of any health insurance plan before it is bought. Ravi Vishwanath, ED and CEO, Reliance Health Insurance, says, "Our health insurance plan offers also offers 90 days pre and 180 days post-hospitalisation benefit. Customers requiring hospitalisation due to menopause-related problems and neurodegenerative disorders can claim all medical expenses arising out of the treatment, during the full course of 270 days under pre and post hospitalisation benefit up to the sum insured level."

Insurance prices

The effect of Irda's guidelines on premium charges is yet to be seen as insurance companies are busy comprehending the draft guidelines and deciding their plans accordingly. However, an increase in the scope of coverage is bound to push the premium prices higher.

No bar on incentives

In-built policy benefits including restore benefit, multiplier benefit, etc, are factors that distinguish a plan from the other. Subrata Mondal, executive vice president, Iffco Tokio General Insurance, says, "All policy benefits like restoration of the sum insured, etc, will continue as they are incentives for pursuing good health practices."

The concept of mental health has always been deemed a taboo in India. Lack of awareness and misconceptions about the same have only aggravated the conditions under which they are treated. The burden of expenses on long-term out-patient treatment (OPT) has resulted in limited treatment options. Naval Goel, CEO and founder, PolicyX.com, says, "The new guidelines by Irda are highly impressive. Increasing the basic health insurance plan with such added features and extended coverage will surely increase the penetration rate of health insurance in India. With such a wider cover, people who fall in any of the aforementioned categories can easily invest in the appropriate plan and can get the required cover on time."

(The writer is Abeer Ray.)

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Source

Health cover gets better, broader - The Hindu Business Line – 28th May 2019

A spate of regulatory reforms have been brought recently and much more is in the pipeline.

In terms of providing cover, the reach is being expanded by revisiting present exclusions, which are detrimental to the interests of the policy holders.

The Insurance Development and Regulatory Authority of India (IRDAI) is now looking at banning key exclusions to protect the interest of health insurance policy holders on the basis of recommendations of its working group.

If approved, in future, no health insurance policy should incorporate exclusions such as diseases contracted after buying the health cover, injury or illness associated with hazardous activities, and impairment of a person's intellectual faculties from drugs and stimulants or depressants prescribed by a medical practitioner.

Waiting period

The regulator is also looking at streamlining key issues concerning expenditure incurred by critical-care patients and its cover under health policies.

On the claims front too, some novel moves are on. The regulator is considering the option, whereby the policyholder can receive the amount in lump-sum or in equated instalments.

This will not be a default mode, but should be implemented only if a customer opts for it.

The periodicity of instalments could be monthly, quarterly, bi-annual, and annual. The claim payment period could be up to a maximum of five years, and instalments should be spread over the payment period.

The waiting period is also likely be reduced. The regulator is examining the possibility of reducing the waiting period for lifestyle diseases related to hypertension, diabetes and heart ailments to less than 30 days. Generally, the waiting periods is now 90 days or more.

Gross premium underwritten by 31 non-life insurance companies, which also has health insurance as a component, increased 12.91 per cent to ₹ 1,70,111 crore in FY19 against ₹1,50,662 crore in the previous fiscal.

The standalone private health insurers witnessed a 37 per cent increase in their combined premium to ₹11,368 crore in the financial year ended March 2019, against ₹8,314 crore a year ago.

(The writer is G Naga Sridhar.)

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Source

Compulsory mental health cover in medical policy likely to make it more expensive – Moneycontrol – 28th May 2019

Health insurers will have to compulsorily include mental health under the list of ailments covered by medical insurance policies. Only those policies which provide disease-specific cover, such as for diabetes, cancer among others, are exempt from this rule.

Industry officials said that the inclusion of mental health cover would make policies at least 20 percent more expensive than disease-specific policies.

"Therapy sessions are expensive in India with average cost of Rs 1,500 per sitting with a psychologist. If this is a default inclusion across health insurance policies, costs will go up," said the head of underwriting of a private general insurance companies.

The Insurance Regulatory and Development Authority of India (IRDAI) on May 16 issued an exposure draft on the standardisation of health insurance exclusions and said that mental illnesses could not be excluded from health insurance coverage.

All existing health insurance products that are not in compliance with these rules have to be withdrawn by April 1, 2020.

With the Mental Healthcare Act being passed, offering insurance for mental ailments has been made mandatory by law. Under the Act, every insurer has to offer medical insurance for treatment of mental illness on the same lines as insurance for physical illness treatment.

However, insurers are still very selective in offering such covers. Only three insurance policies cover mental illnesses treatment and selectively offer the coverage for only cases of hospitalisation.

Now, IRDAI has said the treatment of mental illness, stress or psychological disorders and neurodegenerative disorders will have to be covered.

Among other things, the use of drugs/anti-depressants prescribed by a medical practitioner would also be a part of health insurance coverage. Similarly, failure to seek or follow medical advice or failure to follow treatment cannot be used as a clause to deny medical insurance.

Anti-depressants like Xanax and Prozac are only sold on the advice of a doctor. Extreme cases that require medical supervision also require multiple therapy sessions complemented by pills. These cases are outside the purview of the health insurance gamut.

Health insurance officials say that mental illness is a subjective matter and, hence, a limit on the amount of coverage cannot be decided. Therapists usually study the symptoms of each individual patient to diagnose if he/she has clinical depression.

IRDAI has not clarified what mental illness means. Insurers will seek clarity on this aspect and what are the exact cases of anxiety/depression that will have to be mandatorily covered under health policies.

(The writer is M Saraswathy.)

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Source

Claim settlement process of health insurance: TPA Vs In house claim department - The Economic Times – 28th May 2019

The claims settlement process is one of the most important aspects of an insurance policy, especially if it is a health cover. A policyholder's health insurance claim can get settled by an insurer in two ways: third-party administrators (TPA) and through the insurer's in-house claims processing department.

You should know that TPAs are available only for processing of health insurance claims, i.e., there are no TPAs for other kinds of claims like life or motor. There are advantages as well as disadvantages of both methods of claims processing.

What is a third-party administrator?

A TPA is basically a middle man who facilitates the settlement of a health insurance claim. A TPA is appointed by the insurer. TPAs help you (the insured) process your health insurance claim using various hospital bills and documents. However, they are not responsible for claims rejection or acceptance.

Vaidyanathan Ramani, Head Product and Innovation, Policybazaar.com says, "You need to contact the TPA as soon as the claims process starts. All kinds of assistance related to claim settlement is provided to you by the TPA from the process perspective until the claim is done/settled. Here what you (policyholder) should know is that the acceptance and rejection of the claim is the job of the insurance company and not of the TPA."

Many insurers have a tie-up with a TPA company. Ramani said that there are 26 companies in India authorised by the Insurance Regulatory Development Authority of India (IRDAI) to act as TPAs. Health insurance companies can have a contract with any one of these TPAs and the insurer's claims processing department would then be associated with the contracted TPA, Ramani added.

Among the TPAs, Health Insurance TPA of India is the one that caters solely to claims relating to policies issued by public sector insurers. One can directly visit their website and find out the network hospital providers and TPAs.

What is an in-house claims processing department?
In the in-house claim settlement process, instead of taking the services of a TPA company, insurers set up an entire department within their own company to act as in-house claims processing department. The in-house claims processing department is also known as HAT (Health Administration team).

Rakesh Goyal, Director, Probus Insurance, a Delhi- based online insurance broker, said that one of the major advantages of having an in-house claim settlement process is that the turnaround time (TAT) for resolving a query or claim is faster and hassle-free as the decisions are directly taken between insurers and policyholders since there is no TPA in between. "So, for instance, if you are getting your health insurance claim processed through a TPA you need to submit all the details to the TPA and then they will get your claims settled by the health insurer. However, in case of the in-house claim settlement process, the health insurer will directly deal with you and the concerned hospital and settle the claim probably within a few hours or a day itself," Goyal said.

Nowadays, many insurers have their own in-house departments to handle the claims process, especially for the retail health portfolio. But, there are some points to consider as to what can work better under different circumstances, Ramani explains:

Advantages of in-house claims processing department over TPAs
The insurer builds a key differentiator on the claims handling front, around TAT and other facilities. Building an in-house claims process allows the insurer to provide special offerings to their policyholder from time to time.

TPAs cannot take any judgement on claims and are only allowed to process them. So, if there are a large number of cases requiring a formal judgement (on applicability or quantum of cover), a TPA may be inefficient and will end up escalating most cases to the insurer only. So, in case of in-house claims processing department where the entire process is done within the insurance company itself, claim process is more hassle-free and takes less time as compared to TPAs.

TPAs are dependent on the insurer for getting the health insurance claim settled for the policyholders.

Thus, the efficiency of a TPA depends on how tight its terms of operations are and how clearly the processes are defined for them by the health insurer to process the claims they receive.

Advantages of TPAs over in-house claims processing department
According to Ramani, TPAs have their own hospital networks which is mostly larger than an in-house claim settlement department of an insurance company. The extent of coverage provided by some of the largest TPAs for cashless is higher than most insurance companies in India.

TPAs are focused toward claim management process and have streamline processes for it.

"While in case of in-house claims settlement, policyholders have to go through the customer care route, it may take time in explaining the complete scenario to the insurer," added Ramani.

Comparative analysis
According to Ramani, one may expect a difference between claims settlement process in health insurance by in-house department and TPA to be in terms of TAT, which is important from the policyholder's perspective.

This is likely to be the reason why many large private insurers like Religare Health Insurance, Apollo Munich Health Insurance, Max Bupa Health Insurance, Bajaj Allianz Health Insurance, and HDFC Ergo General Insurance have in-house claims processing department. But there are still many private health insurers who do not have their own in-house claims processing department. Further, none of the PSU health insurers have in-house departments to process claims.

However, at an overall level, there is not much difference between the outcomes from a TPA and the insurer's in-house claim processing department. This is because both implement the process that has been set up by the insurance company, in favour of its policyholders. Both help in processing health

insurance claims as per IRDAI rules and regulations. Goyal said, "Even if we look at health insurance claims handled through TPAs and directly by insurers (in-house claims processing department) there is not much difference.

The data from IRDAI shows that, in the financial year 2017-18, both TPAs and insurers (in-house claims processing department) have settled around 91 percent and 91.6 percent, respectively, of claims received by them within three months. However, one thing that policyholders should know is the claims settled in-house took much lesser time as compared to TPAs," said Goyal.

What should policyholders of PSU insurers do?
If you have a policy from a public sector health insurance company like National Insurance, The Oriental Insurance, The New India Assurance, and United India Insurance, then you have to process your health insurance claim through their TPAs.

A PSU insurance agent who did not want to get quoted said, "You don't have to pay any additional charges for the TPA services."

Anand Shrikhande, CEO, Quickinsure, a Mumbai- based insurance broker, said PSU insurance companies do not have in-house claims processing facilities. They rely on TPAs for all claim settlements. For providing claim settlement services, the TPA generally charges the insurance company 6 percent of the claim amount. "However, PSU insurers' policy pricing takes care of this and does not pass the premium charges to the policyholder. Hence, as a policyholder, TPA charges does not affect you directly," he said.

The insurance agent quoted above said that the TPA of a public sector health insurer has a larger hospital network as compared to a private insurer and all PSU policy holders have to route their claims through a TPA. He also said, "You should not compare both claims process because both have advantages over each other. For instance, mostly the premium pricing of a policy taken from a PSU health insurer is slightly lesser than the policy taken from a private insurer. However, on the other hand, the private insurer settles claims slightly faster than TPAs of PSU health insurance companies."

What policyholders should do
Be it an in-house claims processing department or TPA, both have effective claim settlement process. You should ideally not base your decision on which policy to buy on these two factors rather, you should buy health insurance as per your need and consider policy features, exclusions, waiting period, claim settlement ratio, etc. Not only this, one should always take advice from a financial adviser before buying health insurance.

(The writer is Navneet Dubey.)

TOP

Source

Cancer insurance: All you want to know on how to prepare for various scenarios - The Hindu Business Line – 28th May 2019

The risk of cancer is real. Every year new studies are showing increasing instances of cancer in the country. So, we need not waste time over whether a cancer cover is important.

There are three options for anyone looking for a cancer insurance policy. One, to buy a regular critical illness plan where cancer will be one of the many listed illnesses that will be covered. The second option is to buy any of the cancer-specific plans launched by life insurers which offer more comprehensive coverage compared to CI plans. The third option is to buy indemnity-based cancer plans that come with life-long renewability and are cheaper to the defined benefit cancer plans of life insurers.

Options available
To cover medical costs for cancer treatment (provided you do not suffer from it already), you can buy a cancer-specific policy from a life insurance company; you can also buy a critical illness (CI) policy where cancer is one of the 20-plus diseases that will be covered. The cost of treatment for cancer will be covered under hospitalisation (medi-claim) policies too, but the premium will be significantly higher if you want a cover for higher sums, say ₹20/25 lakh.

Also, the plain-vanilla medi-claim plans may not cover chemotherapy and other procedures which do not require a day's hospitalisation. So, the choice is actually between CI plans of general insurers and cancer plans of life insurance companies. Recently, two health insurers have launched indemnity-based cancer policies, which are very attractive and can be considered too. In indemnity plans, the actual cost of hospitalisation is what is reimbursed unlike the defined plans where the entire cover amount is given on the diagnosis of cancer in the policyholder.

Cancer-specific plans
In CI plans, the major shortcoming is that they cover cancers of only specified severity. Apollo Munich's Optima Vital and Max Bupa's CritiCare, for instance, do not pay out if it is carcinoma in situ (an early stage cancer). Rather, it is better you go for cancer-specific plans offered by life insurance companies such as ICICI Pru Cancer Protect or Max Life's Cancer Insurance Plan or HDFC Life's Cancer Care. The advantage with the cancer-specific policies of life insurers over CI plans is also that they waive premium once cancer is diagnosed. In Max Life and ICICI Pru Life's cancer policies, for instance, premium on the policy is waived off for the rest of the term, if the policyholder is diagnosed with an early stage cancer.

However, when it comes to the time period of coverage under insurance, in CI plans, you get life-long renewability — a key benefit. In cancer policies of life insurers, the policy term is fixed.

Indemnity plans
You have a few indemnity plans, too, in the market that addresses the gaps in the defined benefit cancer plans where the benefit of the policy is paid lumpsum at the first diagnosis of cancer and the policy terminates. The individual in such cases is not protected if the cancer recurs. But indemnity plans such as Apollo Munich iCan and Religare Health's Cancer Mediclaim cover you even after a claim is made.

Also, unlike the plans of life insurers which terminate when the individual turns 70/75 years, these policies are renewable life-long. If you want to cover the cost of hospitalisation for cancer treatment, indemnity plans are a better choice. You can go for defined benefit cancer plans of life insurers if you think you need a back-up to settle the outstanding liabilities.

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Source

Health Insurance Market Value to hit USD 1.5 Trillion by 2025: Global Market Insights - New Kerala – 28th May 2019

Growing awareness regarding availability of health insurance policies having several benefits will drive the regional business growth. Furthermore, favorable regulatory landscape for health insurance companies in the U.S. positively influences industry growth.

Private segment of health insurance market was valued at over USD 530 billion in 2018 and will witness robust growth. It provides economic support to patients receiving treatment from quaternary, tertiary and secondary healthcare institutions. Moreover, private insurance plans also aim for imparting greater flexibility to customer for choosing doctors and treatments. Aforementioned factors will foster segmental growth over the coming years.

Hospitalization insurance accounted for more than 20% revenue share in 2018 and will show a significant CAGR by 2025. Insurance providers collaborate with major hospitals to provide reimbursement on expensive surgical procedures and advanced treatments. Introduction of special reimbursement policies by companies such as Cigna and Medicare for complete family health insurance having maximum coverage for diseases further boost the segmental growth.

Global Health Insurance Market is set to surpass USD 1.5 trillion by 2025; according to a new research report by Global Market Insights, Inc. Rising healthcare expenditures will augment the health insurance market growth in coming years. People suffering from cancer and other chronic conditions may require surgical procedures that adds up to healthcare expenses. For instance, according to American Cancer Society, as of 2018 new cases of cancer diagnosed were around 1.6 million in the U.S. alone.

Increasing prevalence of chronic diseases coupled with rising healthcare expenditure is expected to boost industry growth. Moreover, patients that cannot afford surgical procedures and advanced treatment options opt for health insurance plans. Above-mentioned aspects surge the demand for health insurance policies.

Several government initiatives for providing people with effective health insurance policies in developing economies should foster business growth. For instance, National health insurance schemes such as Rashtriya Swasthiya Bima Yojana (RSBY) initiated by government of India provides benefits for the population below poverty line (BPL) that suppresses cost associated with hospitalization. Additionally, recently developed health insurance plans focus on offering coverage to BPL households in an economical manner such factors stimulate business growth. However, poor claim settlement track record system may create complications and restrict the industry growth.

Browse key industry insights spread across 210 pages with 138 market data tables & 10 figures & charts from the report, Health Insurance Market By Service Provider (Private, Public), By Type (Hospitalization Insurance, Critical Illness Insurance, Income Protection Insurance, Medical Insurance), By Network Provider (Health Maintenance Organization [HMO], Preferred Provider Organization [PPO], Exclusive Provider Organization [EPO]), By Demographics (Minors, Adults, Senior Citizens), By Time Period (Life Insurance, Term Insurance), Industry Analysis Report, Regional Outlook (U.S., Canada, Germany, UK, France, Italy, Spain, Russia, Japan, China, India, South Korea, Australia, Brazil, Mexico, Saudi Arabia, South Africa, UAE), Application Potential, Competitive Market Share & Forecast, 2019 - 2025 in detail along with the table of contents

Preferred Provider Organization (PPO) segment held over USD 200 billion revenue in 2018 and will witness robust growth during the analysis timeframe. Segment growth is attributed to low cost of the insurance plans offered by PPO. PPOs allow easy access to benefits of the scheme and individuals are also assigned with primary healthcare professional that reduces hospital visits for minor health issues. Above mentioned factors propel the segment growth.

Senior citizens segment of health insurance market will grow over 2% during the forecast timeline. Majority of geriatric population suffers from chronic diseases. Since, most of elderly people are dependent, they usually cannot afford expensive treatments.

Therefore, increasing adoption of cost-effective public healthcare plans providing reimbursement on various procedures for elderly people that elevates the business growth.

Life insurance segment of health insurance market was valued at more than USD 400 billion in 2018 and will enhance robust growth. Numerous benefits such as lower premium, rising cash values augments the segmental growth.

Life insurance offers different policies that are flexible in terms of policyholder's needs. Moreover, investing in life insurance is an effective method of saving income tax that should positively impact its demand in foreseeable future.

Prominent industry players operating in Health Insurance market include Aetna, Anthem Health Insurance, Blue Cross Blue Shield Companies, Cigna, Humana, HCSC, Highmark, Kaiser Permanente, Wellcare and United Healthcare. Major players adopt strategies such as geographic expansion as well as collaboration to sustain competition in the market. For instance, in March 2019, WellCare collaborated with Centene. This collaboration will help in diversifying WellCare's product portfolio.

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Source

Dental Insurance in India: A Quick Look – Outlook – 28th May 2019

Several health insurance policies are available in India including specific ones like cancer insurance. However, the domain of dental and oral health is often neglected. It might come as a surprise, but dental disorders are on the rise in India with cavities and periodontal diseases being the most common.

Dental health is also associated with other health conditions such as diabetes, cardiovascular disorders, and pregnancy. Due to high intake of tobacco products, India is often referred to as the oral cancer capital of the world.

The overall prevalence of dental cavities in India is 63.9%. It is higher in those who consume a mix diet (74.8%) intake of junk food, among girls (54%), and among the lower socio-economic class (41.7%). The prevalence of periodontal problems is about 16%.

The dental diseases can be a huge financial burden for many as treatment is quite expensive. Dental implants costs around Rs 1-1.5 lakh, facial cosmetic restoration cost about Rs 1.5-4 lakh, fillings cost about Rs 3000-6000 per tooth and root canal treatment ranges anywhere between Rs. 4000 to Rs. 7000.

According to a recent survey conducted on oral health and dental insurance awareness:
- Over 92% agreed upon that they would go for dental checkups and preventive treatment, if it is covered by insurance.
- 85% patients visiting private dental clinics were asked about the importance and use of dental insurance.
- Around 90% of those surveyed expressed interest in buying dental insurance.
- Not only a single patient had any dental insurance and most people were not aware about such insurance cover.

Benefits of Dental Insurance
However, opting for dental insurance can be of use as it can help a lot of people deal with the burden of dental treatment. In order to cover the cost incurred in any dental treatment or procedure, you may choose a health policy that offer cover for dental treatment expenses. Dental insurance covers expenses incurred in dental procedures or treatments such as diagnostic, preventive or curative that are supposed to be necessary by a dentist. You will not get an exclusive dental insurance plan, however under health policies you will be covered for unexpected dental expenses.

Coverage Available under Dental Insurance
Following are the dental procedures that are usually covered under a health plan
- Dental x-rays
- Routine examinations
- Tooth filling
- Tooth extractions
- Root canal procedures
- Follow-up treatments

The dental coverage available depends on the terms specified for a health plan and it may vary from one plan to another.

Dental Insurance Plans in India
If you don't like to pay the huge dental expenses from your pocket, then it's advisable to choose a dental insurance plan for yourself and your loved ones. Let's go through some of the best health plans that are offering dental cover in India.

- Bharti AXA Smart Health
Bharti AXA Smart Health Plan offers complete coverage against all medical expenses arising from in-patient hospitalisation. This plan also provides cover to tackle day to day medical expenses. The medical expenses incurred in Out-patient dental emergency treatment due to an accident are covered.

Note: The dental health plans mentioned above are not the exhaustive ones. You may refer other health plans as well to choose and pick dental insurance for you and your family.

- Apollo Munich Maxima Health Plan
Maxima Health Plan from Apollo Munich offers comprehensive in-patient hospitalisation cover plus out-patient coverage. With this health plan, you will be covered againstday-to-day health problems that don't require hospitalization. This health plan provides an all-round health cover.

Under this health plan, you will get cover for Dental Treatment, Doctor's Consultations, diagnostic tests, spectacles and contact lens as out-patient benefits. The expenses against these medical treatments/procedures are reimbursed up to actual expenses or sum insured mentioned whichever is lower.

- ICICI Pru Health Saver Plan
ICICI Pru Health Saver is a comprehensive health insurance policy that provides in-patient hospitalisation cover for you and your family. It also reimburses all other medical expenses including dental care, diabetes, pregnancy and preventive diagnostic screening.

Under Health Savings Benefit, this health plan reimburses the dental care expenses. You can claim for reimbursement of these expenses on providing the actual bills.

Note: The dental health plans mentioned above are not the exhaustive ones. You may refer other health plans as well to choose and pick dental insurance for you and your family.

(The author Subhash Nagpal is the CEO and Founder, Comparepolicy.com)

TOP

Source

Strategic FDs can help pay health insurance premiums on time - The New Indian Express – 27th May 2019

Your annual health insurance plan is up for renewal, but you cringe looking at the one-time outgo as it dents your monthly disposable income. You put it off for the next month, and then one more, and before you realize it, you run the risk of paying a penalty. Discouraged, you may even discontinue the policy. Sounds familiar?

Most of us would have bought a health plan in earnest based on expert advise, but what's little said or thought about is the source of funds for renewal payments. A few do-it-yourself financial planners, who have taken an ingenious route, say fixed deposits — you heard it right — can help you meet premium payments and even inculcate a renewal payment discipline.

Assuming you take a family cover of Rs 5 lakh, which comes with an annual premium of Rs 25,000-30,000, create a fixed deposit of Rs 4 lakh, which earns an interest income of Rs 28,000 per annum (assuming a 7 per cent interest rate). But, make sure to deposit for 5 years or more to take the higher interest rate benefit as opposed to a one- or two-year deposit.

"By keeping Rs 4 lakh fixed deposit, you and your family can get a life-long medical cover of Rs 5 lakh. The interest from the deposit takes care of the premium requirement with an added bonus of tax benefit," says Venkatesh Jayaraman, an individual investor based in Bengaluru adding, "Channelize this interest amount towards annual premium."

A simple health plan for a family of four (two adults and two children) worth Rs 3 lakh costs even less (below Rs 10,000) depending on age and medical history, the renewal premiums can be taken care of by a fixed deposit as low as Rs 1.5 lakh. But, what do you do if annual premium increases, but not interest income on the deposit? The increase in premium is generally negligible unless of course, you increase the total cover. In the latter case, you may have to accordingly increase the deposit amount. Missing renewal payments and eventual policy discontinuity will be a death blow as the policyholder will have lost out on the waiting period limits.

Meanwhile, unlike life insurance policies, which offer the flexibility of a monthly, quarterly, half-yearly and annual payment option, it's easier said than done for health or motor insurance, which are prone to frequent and high claims settlements. Though a few players like Future Generali toyed with the idea in 2016, such plans were not without riders. For one, the premium charged was higher than the standard rates. Moreover, policyholders will have to go through the full 12 months when instalments are paid to stake claim to the insurance money, unlike regular policies where annual premiums are paid upfront.

Nevertheless, sector watchdog IRDAI is considering allowing an equated monthly instalment option for health premiums, as it makes the products affordable, and allows policyholders to even seek a higher cover as premiums, when sliced into EMIs, are easier to bear. But, it's important to note that instalments, irrespective of the product, always make the actual cost of the product higher. Another option currently available to policyholders is to pay premium through credit cards and convert it into EMIs, which of course comes with an added interest component.

How does this system work?
Assuming you take a family health cover of H5 lakh, which comes with an annual premium of H25,000-30,000, create a fixed deposit of H4 lakh, which earns an interest income of H28,000 per annum (assuming a 7 per cent interest rate). But, make sure to deposit for 5 years or more to take a higher interest rate benefit.

(The writer is Sunitha natti.)

TOP

Source

State to levy fee on health insurance – The Times of India – 26th May 2019

With many corporate hospitals denying treatment to such patients due to pending dues from the government, the health department was forced to come up with a plan to include 'employee contribution' in the scheme. In the central health scheme, monthly contribution starts at Rs 250 and goes up to Rs 1000'. According to sources, the charges would be up to Rs 500 in the state scheme.

After toying with the idea of revamping the state government's employee health scheme from a cashless and free of cost scheme to a paid one, the health department has decided to levy charges up to Rs 500 per

month for the health coverage. Framing the scheme on the lines of the central governments scheme, the health department's decision will affect nearly 20 lakh patients (state government employees and their families).

"Many empanelled hospitals have been denying services to the state government employees as they are unsure of payments. There are already pending amounts and the state government does not have enough funds to pay. To sort out the crisis, the new model is being planned," a health department official said. TNN

Source

TOP

When should you dump your health insurance cover? - The Economic Times – 26th May 2019

A health insurance policy is a must in any protection portfolio. However, in some situations, continuing with a policy may not add value to your protection portfolio. The following scenarios illustrate how and when a policy renewal or purchase may cease to be healthy.

Hikes in renewal premiums

In recent years, some senior citizens have had to deal with up to 100% increase in their health insurance renewal premiums. Faced with the prospect of not being covered at a time when they need it the most, many have continued to service such premiums. However, financial planners do not advocate this approach. "A cover with a premium-to-sum assured ratio of more than 20% is not viable," says independent financial planner Bhakti Rasal.

You should put your policy on watch even if the premium crosses the 10% threshold. For example, if you are a senior citizen with a Rs 4 lakh cover and your renewal premium shoots up to Rs 54,000 per annum, let the policy lapse, particularly if it also comes with co-pay or room rent restrictions. "If the premium amount crosses 10% of the sum insured, study its utility before taking a call. If it goes to as high as 25%, it makes no sense," says Suresh Sadagopan, Founder, Ladder7 Financial Advisories.

In such circumstances, you would be better off building a separate, medical emergency fund by setting aside the required amount in a fixed deposit or identifying substitutes.

Room rent sub-limits

Consider this scenario: you bought a Rs 3 lakh cover 20 years ago, when you were 45, with a room rent limit of 1% of the sum insured (Rs 3,000). The amount was enough to take care of hospital bills and get you a room of your choice. Now the premium has gone up to say Rs 22,000, and the room and hospital you prefer are of premium variety. What served you well for 10 years may not meet your requirements going forward. In this scenario, the total claim payout will be reduced heavily, as the overall charges—doctor's fees, anesthesia, OT charges etc—are linked to the room rent category. If you have chosen a room that costs Rs 5,000, while you are eligible for a room type that costs Rs 3,000, there will be proportionate deduction of 33% on all charge heads. Therefore, if your claim amount is say Rs 1.5 lakh you might end up receiving only around Rs 1 lakh. Your total outgo, therefore, would be Rs 72,000, which does not justify a renewal. "If there are sub-limits, co-pay conditions as well as exclusions from coverage, it is a better idea to create a medical contingency corpus," says Sadagopan.

*After 33% proportionate deduction; registration and non-medical expenses are exclusions. Illustration based on a range of premiums for a 65-year-old female.

Do ensure, however, that you do not go overboard hunting for a feature-rich policy with the largest possible sum insured only to maximise tax benefits. Ideally, a family of four, where the eldest member is

under 40, should start with a cover of Rs 5 lakh and review requirements and medical inflation every five years and hike cover accordingly.

Co-pay, disease-wise capping

If you are paying a premium of Rs 35,000 for a Rs 4 lakh policy that comes with a co-pay of 20%, evaluate your cover. If your approved claim is Rs 1 lakh, the actual payout will be Rs 80,000. Your total outgo would be Rs 55,000, not factoring exclusions for registration and non-medical charges. Similarly, disease-wise cappings, too, can blunt your cover's utility. Here, the payout for certain diseases, surgeries or charges can be restricted to an ad-hoc amount or 25-50% of the sum insured.

Higher premiums at older ages

While insurers and experts recommend buying a health policy at a younger age to ensure favourable terms and conditions, many realise the need as they grow older, or when they suffer from ailments. Insurers do extend covers to such individuals, but with prohibitively high premiums and restrictions. "If a person suffers from severe pre-existing conditions and is issued insurance with many restrictions then it may not be worth buying," says Kapil Mehta, Co-founder, Securenow.in.

The alternatives

Your claim experience with your insurer also counts. "If your insurer consistently rejects your claims, it may be better to move," says Mehta. If you are facing an insurer-specific challenge, port to another if a better deal is being offered. There are other options in addition to creating a health contingency fund. "Instead of regular health insurance, go for a critical illness or a cancer plan. At least one expensive disease is covered. You could also buy top-up insurance if the base policy is too expensive," says Mehta. Top-up add-ons come into the picture only after a pre-agreed amount is exhausted. The decision to let go of your policy should be taken carefully after exhausting all other options. Once lapsed, it will not be easy to sign up for another. "Health insurance is the perfect tool as it is a yearly contract and comes with guaranteed lifelong renewal. It has the ability to act as the perfect wealth protector in one's portfolio. Any size corpus would get exhausted while the cover gets renewed every year," points out Ravi Vishwanath, ED and CEO, Reliance Health Insurance.

(The writer is Preeti Kulkarni.)

TOP

Source

MoU to develop uniform standards of cancer patient care under PMJAY - The Economic Times – 26th May 2019

The National Health Authority (NHA) and the National Cancer Grid (NCG) have inked an MoU to develop uniform standards of patient care to battle cancer under the central government's health insurance scheme Ayushman Bharat. The NCG is an initiative of the government to create a network of cancer centres, research institutes, patient groups and charitable institutions across the country.

Owing to multi-disciplinary nature of care required for cancer management, both NHA and NCG recognise the importance of collaborative efforts required to strengthen delivery of cancer services under Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY).

The aim is to reduce cancer burden, improve access to cancer services and ensure financial risk protection with minimum prevalence of catastrophic health spending and impoverishment, an official statement said.

NCG and NHA officials met in New Delhi recently to discuss their new partnership on a wide range of ideas to improve cancer care.

"The main objectives of this collaboration include developing uniform standards of patient care for prevention, diagnosis, and treatment of cancer, providing specialized training and education in oncology and facilitating collaborative basic, translational and clinical research in cancer.

"NHA and NCG will jointly review existing cancer treatment packages, pricing of services, standard treatment workflows covered under AB-PMJAY and plug in necessary gaps to ensure enhanced quality of cancer care," the statement stated.

On this new partnership, NHA CEO Indu Bhushan said, "We are glad to partner with National Cancer Grid and welcome their expertise in enhancing the cancer care services provided under the scheme. We look forward to NCG's support and expertise in enabling us to expand our service delivery network by actively encouraging its member hospitals to empanel with AB-PMJAY."

The PMJAY is the flagship scheme of the government which aims at providing a cover of up to Rs 5 lakh per family per year, for secondary and tertiary care hospitalisation to over 10.74 crore vulnerable entitled families (approximately 50 crore beneficiaries).

PMJAY provides cashless and paperless access to services for the beneficiary at the point of service. According to health ministry, it will help reduce catastrophic expenditure for hospitalizations, which impoverishes six crore people each year and will help mitigate the financial risk arising out of catastrophic health episodes.

TOP

Source

Price cuts, affordable treatment to drive healthcare agenda of Modi 2.0 - The Economic Times – 25th May 2019

With the Modi government being voted back to power, Centre's ambitious healthcare insurance scheme Ayushman Bharat (AB) is expected to get a boost, while there would be greater regulatory pressure on companies to reduce prices, so as to offer affordable healthcare. Along with a bigger push for generic medicines, driving the penetration of Jan Aushadhi centres, and restricting trade margins on all medicines, will be top-most priority of the government, industry experts told TOI.

Over the last five years, the government has already set the agenda by introducing price caps on steeply-priced cardiac stents, and consequently on orthopaedic implants, and expressed its intention to extend them on other essential medical devices.

Among the top 10 promises which BJP made in its manifesto `Sankalp Patra' for healthcare, is to reduce expenditure on health so that all citizens can avail necessary medical services, and to make healthcare accessible. Under AB, it also wants to expand the reach of health and wellness centres, and include provisioning of telemedicine and diagnostic laboratory facilities at these centres by 2022, to ensure quality primary medical care to the poor at his doorstep.

"Clearly, Ayushman Bharat - or the PMJAY scheme - is a huge step forward-- but to make the scheme more inclusive, the middle class should be included (in it). Further, as we make more progress, aligning existing programmes in several states with the PMJAY should be managed, with minimal disruptions. Implementation will be key. A set of issues that have become more prominent in recent months that is crucial for patients are: quality, patient safety and pharmaceutical marketing practices. The quality of medicines - from manufacturing practices to their prescription and use by the patient - is intimately linked with patient safety. The industry has to embrace global standards, like the WHO's Good Manufacturing Practices (GMP). Pharmaceutical marketing practices constitute the third leg in this set of issues; the Uniform Code of Pharmaceutical Marketing Practices", says A Vaidheesh president OPPI, an industry body representing drug MNCs.

Aware of the anomalies which exist in medical packages under Ayushman Bharat, the government has already started the exercise of rationalising reimbursement rates between different states. It expects some convergence in rates once there is collective bargaining for major devices and supplies, as the scheme matures.

"The success of AB will depend on how much funds are allocated to upgrading the district and medical colleges to reduce the dependency on private sector. The policy will also have to stress on opening up more preventive and primary healthcare centres, along with focus on people getting access to tertiary care. This scheme has included 1.5 lakh wellness centres dedicated for primary care, and once these are operational the load on tertiary care will come down. The success of the scheme will be largely dependent on private providers' participation", Joy Chakraborty COO, P D Hinduja Hospital said.

(The writer is Rupali Mukherjee.)

TOP

Source

Health Insurance: Secure your family with a Family Floater plan – Financial Express – 25th May 2019

One of the most important things in this world is family, and to be able to take care of one's family's needs financially and the health of every loved one is what matters the most. In this increasingly fast-paced life, accidents and ailments strike without warning and the treatment cost of a single family member can impact an entire family. The most appropriate financial planning tool available to ensure the safety of one's loved ones is a Family Floater health insurance plan that covers each family member.

Although people are conscious of the need of a healthcare plan, most do not know which plan to buy, i.e. whether to spend on a personal health plan for each family member or to purchase a Family Floater plan. Individual healthcare policies offer coverage for a single person with a specific sum insured. On the other hand, in a family floater plan, the sum insured can be utilised by any of the family members listed under the cover. A family floater plan covers all the members of a family under one single umbrella of health insurance.

To understand how a Family Floater plan works, here is an example: Mr. Verma has purchased a family floater plan with a sum insured of Rs 10 lakh to cover his family – self, his wife and their two children. During the policy tenure, he is diagnosed with dengue and as a result he is hospitalized. His treatment costs around Rs 3 lakh. Under a family floater plan, he is able to claim this amount from his insurer and obtains reimbursement after submitting the required documents and proof. Under his family floater plan,

he still is left with Rs 7 lakh for the rest of the year, for himself, his wife or children, in case the need arises.

With a Family Floater plan, a policyholder is able to obtain a wider coverage for the whole family at an affordable premium, under a single policy. There are several additional benefits of having a family floater such as reimbursement of ambulance charges, OPD coverage, AYUSH benefits, and a health checkup for every claim free year, domiciliary hospitalization expenses and cover for all day care procedures.

Also, some Family Floater plans offer automatic restoration of the sum insured. The advantage is that there is no way the policy can run dry, even if the entire sum insured is exhausted. We all love and care about our families and that's the reason we go the extra mile to keep them safe. And, a Family Floater plan exactly does that.

Stay Healthy! Stay Invested!

(By Anand Roy, Executive Director, Star Health & Allied Insurance Co Ltd)

TOP

Source

Insurance cos may seek extension to include mental illness – The Times of India – 25th May 2019

Even as the Insurance Regulatory and Development Authority of India (IRDAI) is pushing for insurance cover for mental illness, industry representatives seek more clarity on the definition of the emerging category. While the Mental Healthcare Act, 2017 says there must be no discrimination between physical and mental illness, insurance players are faced with challenges given there is no information relating to prior claims made for treatment of mental illness.

Industry representatives TOI spoke to said companies are working to get more clarity on the definition of the ailment, requirement of hospital care, and pricing among others. "It is vital to ask the regulator what is the definition of mental illness.

For example, the regulator has listed illness of menopause has to be included too. We all know how depression is also a side-effect of menopause in many cases. Is such case, how do we map it?," Subramanyam Brahmajosyula, head of underwriting and reinsurance, SBI General Insurance, said. Industry players said it is difficult to arrive at a pricing model and tweak it for various scenarios, and also count the stigma around the illness to be a key challenge.

There is no prior data collated by the industry on mental ailments, since many fear to record their mental illness, they said. "How do you price a mental illness? It does not have a treatment cost, it may also be periodical and be non-stop," an industry representative who wished to not be named, said. There is also the issue of the rise in overall policy cost for all holders, making it commercially unviable to draw such a policy, he added.

SBI's Subramanyam said offering feedback to the regulator within the deadline of May 31 will be difficult. "We will be requesting for an extension of one week," he said. Among the various conditions GIC aims to propose for mental health coverage are a waiting period for policyholders already diagnosed with the illness to make claims, sub-limits and caps set for treatments, and timing of treatments, etc. "Finally, there must be a system of co-pay, in which the policy holder has to bear 10% of total cost of treatment," he added.

Shanai Ghosh of Edelweiss Gen Insurance said that there will be more clarity as the industry gathers more data on claims, making it easy to arrive at a more accurate pricing.

However, Ashish Mehrotra, MD and CEO, Max Bupa Health Insurance, noted that even a year's data may not be enough Insurance, noted that even a year's data may not be enough to draw any conclusions, and the industry would need at least three to five years of data.

(The writer is Mamtha Asokan.)

TOP

Source

MOTOR INSURANCE

Modifications affect Your Insurance. Here's how? - The Hans India – 29th May 2019

Are you a car enthusiast who's forever seeking to improve their car's looks and performance? If yes, then 'modifications' must be big on your mind. From getting extra headlights to up your car's style quotient to fitting alloy wheels or air filters to better its functionality and performance, you love the idea of modifications. However, did you know that modifications don't just alter your car, but also its insurance cover?

Yes, every change that you make to the manufacturer's original vehicle amounts as a modification. Therefore, it is essential that you know more about how it affects your insurance to take better decisions. Car Modification from Insurer's Point of View While you know what the term means, but when it comes to understanding it with respect to insurance, then you might not be as clear. Car modification in insurance includes anything that makes your car look or perform differently, as compared to what it was when the brand manufactured it.

Modifications also include any add-ons that you may have bought from the seller. Some of these might come with the car itself, so you may not realize it, but you may be paying more premium because of that Car Modifications and Its Impact on Insurance Premiums Insurance is very strongly connected with the risk factor. So, when quoting for insurance cover, insurers consider all aspects related to risk. The two such aspects are as follows-

1. Risk of Theft: Some modifications like getting phone kits or performance-oriented ones make your car slightly more vulnerable to getting stolen or being broken into.

2. Risk of an Accident: Some modifications related to change in look and performance of the car increase the chances of an accident. For instance, some of you may get changes done in the suspension, gear transmission, brake control and get tinted glasses, body kits, etc. However, later, these modifications may be considered as a possible cause behind the accident, which is actually the case at times. Therefore, insurers always take modifications as a possible cause in advance. Hence, they charge a higher premium for the same.

What Modifications Impact Your Car Insurance?

1. Modifications to Engine and Mechanics Many of you get supercharger, or turbo added to your car's mechanics, to get 'faster acceleration' or 'sports car type feel' to your car's movement. However, such modifications are often seen to increase the risk of accidents. Therefore, insurers can charge a higher premium from you in such a case.

2. Suspension and Brakes If you get your brakes or suspension modified, then its behavior on the road will most probably be altered. Therefore, this, too, must be declared to your insurer.

3. Wheel Modification Any modification to the wheels of your car will significantly affect its handling. Whether you get wider wheels or alloy wheels or get them upgraded, you should mention about the same to your insurer.

4. Paintwork Though getting your car repainted or adding racing designs may look like a harmless modification, but you still need to inform your car insurer about the same. So, next time, you think of changing the look of your car with some paintwork, consider the increase in insurance costs.

5. Interiors You may get your car's interiors like steering wheel, dashboard, seats, or sound system changed. This may alter your driving experience in different ways. Therefore, all such modifications are required to be shared with the insurer.

What Modifications Do Not Affect Your Insurance?
Although every modification will impact your insurance by increasing the premium to be paid, however, there are a few modifications that do not affect your insurance as they are considered to reduce the risk associated. For instance, getting parking sensors fitted in your car reduces the risk of collisions and crashes. The insurance companies will not consider thisas a modification and will thus, not charge any extra premium.

Simple modifications do not increase the insurance premium by a considerable amount. Only notable ones that cause a significant change in the car's performance make the insurance costs to go up.

Why Should You Declare Modifications to The Insurer?
It is essential that as a policyholder, you maintain maximum transparency between you and the insurer. Along these lines, inform the insurer about all the big and small modifications and let them analyze and decide. Not declaring about the changes may lead to claim rejection and your coverage may become void. This will lead to unnecessary hassles and worry when you need the cover amount. If you buy a second-hand car and are not aware of the modifications, then get your vehicle evaluated from a mechanic. You can then let your insurer know about the changes. However, in any case, do not hide anything from the insurer.

Give Your Car the 'Safety Cover' It Deserves
Caring for your car also implies that you've covered it adequately against uncertain eventualities like accidents, crashes, etc. Having comprehensive four wheeler insurance means ensuring that your car and you are able to deal with unexpected challenges, without facing a financial setback. Moreover, it is mandatory by law too, for every motor vehicle to have third-party insurance cover.

A comprehensive four wheeler insurance cover can provide coverage against loss or damage to your car, along with providing you coverage against any third-party liability that may arise. Some insurers like Tata AIG General Insurance also offer as many as 13 add-on cover benefits for all-around protection. Such benefits include daily allowance when your car is under repair, reimbursement for repair of glass, fiber, rubber parts, etc. You can also get consumables cover and no claim bonus under such add-on benefits.

So, buy the right fourwheeler insurance policy and enjoy all your drives without any worry!

TOP

Source

Benefits of GST Rate Reduction on Car Insurance – Elets – 29th May 2019

The Goods & Services Tax (GST) council met in December 2018 and reduced the GST rates of several items under its ambit. The GST rate for certain items were slashed to 12% from the previous 18%. This is also applicable to car insurance policies. Therefore, the prices of Third-party Car insurance premium will be comparatively lesser. This is good news for the policyholders as they will have to pay less for insuring their cars.

Here are the things to know about GST reduction with respect to third-party car insurance.

The **Goods & Services Tax** (GST) is a unified indirect tax that came into existence in the year 2017, replacing multiple taxes that were levied by state governments. The GST has several slabs and most of the goods are in the 18% tax range. As per the recent ruling, the GST rate for Third-party Car Insurance has been reduced from 18% to 12%.

What is Third-party Liability Car Insurance

Vehicle insurance has two basic components: Third-party Liability and own damage. Buying a Third-party vehicle insurance is a mandatory requirement. It is designed to cover financial losses of parties affected by a car accident. However, it does not cover own damage (of the insured car). For that, you will have to purchase a Comprehensive plan (including Third-party cover).

GST and Car Insurance

Insurance Regulatory and Development Authority of India (IRDAI) is the apex body when it comes to insurance in India. Third-party vehicle insurance rates are stated by the IRDAI. All insurers charge the same amount for Third-party policies by applying the GST rate over the stated cost of the policy. Thus, now that the GST rate is reduced, it will cause a corresponding reduction in the final Third-party insurance rates as well.

Recent Rulings

There have been several important rulings in the recent past regarding car insurance. The most prominent one being the introduction of long-term insurance for new four-wheelers. This means car owners have to shell out more money at one go than they would've in case of an annual policy. However, a long-term policy is comparatively affordable in the long run.

Another ruling was with respect to keeping up with the Pollution norms. One must have the car's Pollution Under Control certificate (PUC) updated to renew car insurance. These two rulings coupled with the reduction in the GST rate are productive from the insurer's as well as the policyholder's point of view.

The authorities have been trying a lot to ensure that all vehicles that ply on Indian roads are at least covered under the basic Third-party Car Insurance policy.

Buy Car Insurance Online

If you are a price-sensitive car owner, then you can opt for a basic Third-party policy. However, if you want to opt for an extensive cover, then it is suggested to opt for a comprehensive plan. It costs more than the Third-party policy but offers enhanced insurance coverage. You also have the option of purchasing Add-on policies if you opt for a comprehensive plan. Some of the prominent add-on policies are: Zero depreciation, Roadside assistance, Invoice protection, Passenger cover, Engine protection, etc.

Irrespective of which type of policy you think of choosing, purchasing it online is the most productive way of doing so. Few years ago, the only way to purchase an insurance policy was the offline method. Nowadays, almost everything can be purchased online. Just as you can open a fixed deposit and invest in mutual funds online, you can also insure your car online. Just remember to read the terms and conditions carefully before purchasing the policy.

(Views expressed in this article are a personal opinion of Animesh Das, Head of Product Strategy, ACKO General Insurance)

Source

TOP

Motor insurance policy expiring soon? You might have to pay a higher premium - The Indian Express – 27th April 2019

People whose motor insurance policy is expected to expire soon - maybe this month or in June - are suggested to renew their policy at the earliest.

Is your motor insurance due for renewal in the next few days, or are you planning to buy a new vehicle anytime soon?

If yes, get ready to spend more money on your vehicle's insurance premium thanks to the IRDAI's (Insurance Regulatory and Development Authority of India) new exposure draft.

As per the latest circular, the regulatory body is soon expected to revise the Motor Third Party insurance premiums for the current financial year i.e. 2019-20.

However, in its last circular, issued in the month of April, IRDAI had put the increase in annual premium for Third Party (TP) policies on hold. Now, with the new circular being released, all insurers will charge the new premiums for Motor Third Party Liability Insurance once revised premiums are implemented.

In line with the IRDAI's exposure draft, the annual TP insurance premium for private cars up to 1000 cc might be raised from Rs 1,850 to Rs 2120. The premium for those exceeding 1000 cc, but not 1500 cc, might be raised from Rs 2,863 to Rs 3,300. However, the TP insurance premium for private cars exceeding 1500 cc, which is currently priced at Rs 7890, is expected to remain unchanged. The average increase in the TP insurance premium of private cars after a detailed analysis is around 15 percent.

In the two-wheeler segment, TP insurance premium for vehicles not exceeding 75 cc might be raised from Rs 427 to Rs 482. For vehicles exceeding 75 cc, but not exceeding 150 cc, the rise might be from Rs 720 to Rs 752, and for vehicles exceeding 150 cc but not exceeding 350 cc, the amount might change from Rs 985 to Rs 1,193. In the two-wheeler segment as well, high end vehicles i.e. vehicles over 350 cc, the premium is expected to remain unchanged. Overall, the expected average increase in the two-wheeler TP insurance premium is 20 per cent.

As per market experts, the increments in TP motor insurance premiums between 2012 and 2017 showed it increased by 29 per cent for private cars, and 23 per cent for two-wheelers. In the last financial year, i.e. 2018-19, while the TP premium for cars mostly remained unchanged, while the premiums were reduced for two-wheelers.

As per IRDAI, the introduced exposure draft is open for comments till May 29 to allow insurers to give their feedback on the proposed changes. Once the draft is finalised, the proposed TP premium changes would be implemented, after which all the insurers will start charging the same TP premium as decided by IRDAI.

People whose motor insurance policy is expected to expire soon – maybe this month or in June – are suggested to renew their policy at the earliest as they may have to spend more, once the proposed changes are implemented. So if your motor insurance policy is going to expire in the next 45 days, it is highly recommended to renew it now.

(The writer Tarun Mathur is the Chief Business Officer- General Insurance, Policybazaar.com.)

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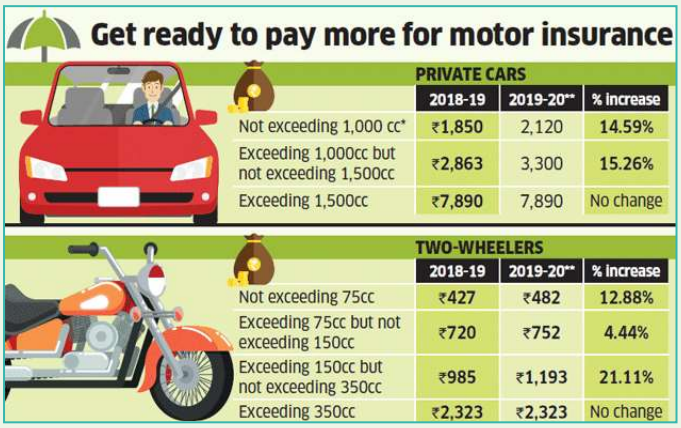
Source

Third-party motor insurance premiums set to rise - The Economic Times – 27th May 2019

You could soon pay more for your two-wheeler and car third-party liability covers this year. The Insurance Regulatory and Development Authority of India (Irdai) has proposed to increase private two-wheeler and car third-party liability rates by 4-21% for the financial year 2019-20. The highest percentage rise of over 21% will be seen in two-wheelers with engine capacities between 150cc and 350cc.

From Rs 985 in 2018-19, the rates could go up to Rs 1,193 if the exposure draft is finalised in the current form. Among private cars, owners of cars with engine capacities between 1,000cc and 1,500cc will have to brace themselves for a 15.26% rise, with premiums going up from Rs 2,863 to Rs 3,300.

The insurance regulator said it has taken into account data provided by the Insurance Information Bureau of India (IIBI), besides claims paid data for the years 2011-12 to 2017-18 and gross written premiums for these financial years while arriving at these rates.



**Engine capacity. **Proposed. Source: Irdai*

The premium segments – two-wheelers with engine capacity exceeding 350cc and cars with engine capacity of over 1,000cc – however, have been left untouched. In addition, the regulator has proposed a discount of 15% on motor third party premium rates for electric cars and two-wheelers.

Private cars identified as vintage cars by the Vintage and Classic Car Club of India will be eligible for a 50% discount on the proposed rates. Three-year and five-year single premium rates for new cars and two-wheelers respectively will remain unchanged. On directions from the Supreme Court, the insurance regulator had introduced long-term third-party liability premiums for new cars and two-wheelers from 1 September.

Rates are usually revised in April by 10-20%, but the Irdai had chosen to leave them unchanged back then. It has now sought comments from all stakeholders to the exposure draft by 29 May.

TOP

Source

CROP INSURANCE

Government mulls algorithm boost to farm insurance payouts - Hindustan Times – 27th May 2019

The Union agriculture ministry is looking at algorithms to fix delays in paying farmers their claims under the Pradhan Mantri Fasal Bima Yojana (PMFBY), a major issue hobbling the flagship crop insurance scheme.

The government is experimenting with big data analytics, artificial intelligence (AI) and machine learning to quicken assessment of crop damage, a lengthy and often disputed mechanism, people familiar with the matter said. If the PMFBY is to achieve its most critical goal — timely payouts to farmers — it can't fly without a raft of high-end technological fixes, experts say.

Analysing the scheme's design in his recent work 'Supporting Indian Farms the Smart Way', economist Ashok Gulati predicted that, for prompt crop insurance settlement, India could even need a fleet of cloud-

penetrating satellites for faster crop-loss estimates. Setting up such a constellation would likely cost Rs 2,000 crore, according to Gulati's calculations.

The government has taken the first few steps in harnessing high-tech and the results are "optimistic", an official said.

This rabi season, the government partnered with CropIn, a Bangalore-based AI firm, to infuse big data analytics into a British-era method of estimating yield losses, called "crop cutting experiments". The exercise was carried out in Kerala, Madhya Pradesh and Karnataka under the crop insurance programme.

India plans to scale up use of AI in a range of public programmes, according to a document of the Niti Aayog. In a letter, its CEO Amitabh Kant urged states and central ministries to explore use of AI in health care, agriculture and education sectors.

The agriculture ministry has issued fresh bids for tech solutions and similar trials to bring down the "unit" of the crop insurance programme to the level of "gram panchayat" or village during the 2019 June to September kharif season.

Launched in 2016-17, the PMFBY has been dogged by delayed payments to farmers. Prompt payouts to farmers suffering crop losses hinge on accurate estimates of yield loss, arrived at through crop-cutting experiments. Often, insurance companies tend to dispute yield loss data sent by states, rejecting or delaying claims. "This is where newer technologies can intervene and bring transparency," an official said.

Norms require four crop cutting experiments at every village. This means the country must conduct about 7 million such experiments to estimate yields, an official said. This is the stage in yield-estimation process where high-tech is being brought in. For instance, the brief given to CropIn was twofold. One was to help reduce the number of farm locations for conducting crop cutting experiments to save time. Two, how could AI help give better idea of yield and output? CropIn used its remote-sensing tool called SmartFarm to glean information of the current and previous years to "identify homogeneity and heterogeneity of expected yield", the firm's head of R&D Richa Hukumchand said.

SmartFarm's algorithms too can zoom in on farms through remote sensing and by reading pre-assigned digital signatures for specific crops, they can identify the crop, its maturity stage and other parameters. SmartFarm has estimated that crop cutting experiments can be reduced by 30%.

(The writer is Zia Haq.)

TOP

Source

INSURANCE CASES

Is CM's health insurance scheme being reviewed periodically, asks Madras HC – The Times of India – 30th May 2019

The Madras high court has directed the state government to file a report explaining its stand on a public interest litigation (PIL) seeking to revise the tariff of treatments which can be availed under the Tamil Nadu Chief Minister's Comprehensive Health Insurance Scheme (TNCMCHIS).

A vacation bench of Justice R M T Teekaa Raman and Justice P D Audikesavalu heard the PIL which claimed that only 30% of the cost of treatment of certain diseases was covered under the scheme at present and patients were left with no choice but to pay the remaining 70%.

E Sakthivel, a resident of Nagapattinam, sought the court to direct the state government to form a committee to conduct comprehensive cost analysis and enhance tariffs fixed for various medical procedures under the scheme. Petitioner's counsel S Haja Mohideen Gisthi submitted that several diseases contracted by victims of Cyclone Gaja in the recent past were not included in the list of diseases covered under the scheme.

When the plea came up for hearing, the bench raised several queries to the state. The court asked what were the diseases that needs to be included for the benefit of people in the cyclone affected areas of the delta districts and sought to know if any review meeting was conducted by the health secretary for revising the coverage of the scheme and inclusion of further kinds of diseases and treatment for the same.

This apart, the bench also directed the state to report the date of commencement of the existing scheme and the extent of the amount along with the list of the diseases which was covered, the ceiling limit on the cost covered under the scheme and whether any review committee had been appointed to review the smooth functioning of the scheme.

"The special government pleader is required to file a counter touching upon the various averments made in the affidavit and also the points raised by us on the above lines," the court said. "The tariffs for certain treatments under the medical insurance schemes was fixed by the government while introducing the scheme. However, the rates were never revised resulting in low percentage of coverage," the petitioner said.

TOP

Source

Nellore: Insurance firm told to pay Rs 1.4L to claimant - Deccan Chronicle – 28th May 2019

The District Consumer Forum in Prakasam directed an insurance company to pay Rs 1,44,131 to a customer when the firm attempted to deny an insurance claim for repairs to a car after it met with an accident under the pretext that it was being used for business.

The Forum pulled up the insurance company for evading the payment under the pretext that the customer was using it for his real estate business. The Forum also awarded a compensation of Rs 5,000 to the complainant, Kanikicharla Prakash Babu of Mangamur Donka in Ongole, for suffering mental agony and inconvenience, besides Rs 2,000 towards costs of litigation to the complainant, while delivering the order recently. In 2012, Prakash Babu had approached the Forum alleging that the insurance firm, Reliance General Insurance Co.Ltd, rejected his claim for Rs 1,76,369 towards repair charges to his car involved in an accident near Inkollu in Prakasam district on May 13, 2012.

He said that he gave his car for repair to the Tata showroom in Nellore as per the directions of the insurance company. He has also carried out some repairs outside the showroom and submitted claim forms to Reliance General Insurance. However, the company sent a letter on August 9, 2012, seeking clarification on the vehicle covering 63,220 km in 13 months, on an average of 160 kms per day. To the surprise of Prakash, the company sought supporting documents for usage of the car.

They did not respond when Prakash said he purchased the car for his own use and never maintained any record regarding the travel. He issued a legal notice on August 21, 2012. Though he did not receive any acknowledgement, the postal department confirmed that it was delivered.

He knocked the doors of the consumer forum in October, 2012, after the insurance firm ignored his letters and notices. Incidentally, the insurance company denied all the averments that were mentioned in the complaint.

They alleged that there was no policy coverage to the accident vehicle on the date of the accident and the complainant had not submitted the required documents or copy of the policy to settle the claim. The insurance firm also alleged that the complainant had not issued any legal notice along with other documents at any point of time.

The firm alleged that there was no proof that the repairs were carried out in an authorised showroom and the bills were not genuine. The complainant had not only submitted the required documents i.e., F.I.R., but also the motor vehicle inspector report and final report of police investigation, along with a copy of the policy to the insurance firm. The Forum heard the arguments of both sides and asked the insurance firm to pay the money. to After hearing the arguments of both sides, the president of the Consumer Forum, S.V. Chalapati and member A. Prabhakar Gupta directed the insurance firm to pay the amount.

TOP

Source

Insurance firm told to reimburse Rs 4.25 lakh – Times of India – 26th May 2019

A district consumer forum here on Saturday directed HDFC ERGO General Insurance Company Limited and HDFC Bank Ltd. to reimburse Rs 4.25 lakh and pay an additional Rs 1 lakh to a consumer for repudiating his claim without giving a valid reason.

The complainant had submitted that his father purchased a vehicle in the year 2013 by obtaining a loan from HDFC Bank. Upon the insistence of the bank officials, he said that his father opted for an insurance policy from the HDFC ERGO General Insurance Company to cover the loan by paying a onetime premium amount of Rs 6, 438.

He submitted that his father expired on May 30, 2015, and subsequently, he filed the insurance claim. the complainant said that his claim was repudiated by the insurance firm claiming that it is not covered under the policy. Claiming that his father paid all the installments regularly and that he was forced to pay Rs 4.25 lakh and close the loan account, he filed this complaint seeking refund and compensation.

The insurance firm, in their written version, contended by stating that the complainant cannot claim the amount under the credit shield insurance as his father died owing to ailment disease. They claimed this claim doesn't fall under the terms and conditions of the policy. The bank officials, meanwhile, said that they are not liable for said repudiation as they only financed the vehicle. They claimed to be the agents only and added that providing insurance coverage does not arise. During the trial, the Hyderabad-III district consumer forum redressal bench said the fact that the opposite parties disputed repudiated the policy belies their negligence and deficiency in service.

"The terms and conditions submitted by them very obviously includes "Renal Failure", as a critical illness and the policy has to include it and duly reimburse the policyholder," said the bench adding that the insurer was only 59 years old at the time of his death and that his death was certainly premature and unexpected. They said that the opposite parties failed to file any tenable evidence to suggest that he was suffering from any debilitating conditions at the time of acquiring the policy. Apart from refund and compensation, Rs 10, 000 was awarded towards costs of the complaint.

(The writer is Nirupa Vatyam.)

TOP

Source

Insurance firm fined for rejecting death claim - The Tribune – 26th May 2019

The district consumer disputes redressal forum has directed an insurance company to pay Rs 15,59,070 as death insurance claim and Rs 5,000 as litigation expenses to an insured's widow. The insurer had earlier repudiated the claim on the ground that the policy holder hadn't given details of his medical history at the time of obtaining policy.

Nimmo, a resident of Khanwal village, had filed a complaint against PNB MetLife insurance stating that her husband obtained a life insurance policy from the opposite party with a sum assured of Rs 15,59,070. Nimmo said her husband expired during the policy period and as a nominee she filed for the claim which was repudiated on the reason that her husband Amar Singh was suffering from tuberculosis and cancer prior to policy issuance.

The opposite party, in its reply, stated that as the insured died within a short span of three months from the time of purchase of policy and the company would hold a inquiry. The opposite party in its reply stated that the insured did not provide true and correct information while filling up the proposal form.

The opposite party claimed that the insured was suffering from tuberculosis and cancer prior to the issuance of the policy.

Forum president Charanjit Singh and member Rachna Arora said that the opposite party could not produce any medical treatment record to prove that the deceased was suffering from tuberculosis and cancer or he had knowledge that he was suffering from the said disease prior to inception of the policy.

It further stated that moreover there was no bar on the opposite party to get the thorough medical checkup at the time of issuance of the policy. The opposite party was within their right to cancel the policy if it doubted or found any information supplied by the life assured being false or wrong, but this has not been done, the forum stated.

What goes against firm

While repudiating the claim filed by Nimmo, wife of deceased Amar Singh, PNB MetLife accused the policy holder of concealing details regarding his medical history at the time of buying the insurance policy. Forum president Charanjit Singh and member Rachna Arora said that the firm could not produce any medical treatment record to prove that the deceased was suffering from tuberculosis and cancer or he had knowledge that he was suffering from the said disease prior to the inception of the insurance policy.

TOP

Source

PENSION

EPS 95 Pension Latest News: Delhi High Court judgment for employees of exempted organisations – Financial Express – 28th May 2019

There is good news both for the employees and those who have retired from any of the exempted organizations. The High Court of Delhi on May 22 has delivered a judgment that is in favour of the employees of the exempted organization governed by the Employees' Provident Fund Organisation (EPFO). This judgment after the all-important judgment of the Supreme Court in 2016, which had given its judgment favouring the employees of the un-exempted organisations is to bring cheer to the retirees of the exempted firms as well.

According to the judgment, even the employees of the exempted firms will be entitled to higher monthly pension on the basis of the contribution on the actual salary without any reference to any cut-off date or any ceiling limit of the salary. An organization having its own Trust to manage provident fund is an exempted organization while that managed by the EPFO is an un-exempted organisation.

The 2014 EPFO notification

Employee's Pension Scheme (EPS 95) had its rollout in 1995. Initially, the ceiling was Rs 5,000, which was raised to Rs 6500 in 2011 and then to Rs 15000 in 2014. A portion of the employer's share, 8.33 per cent to be exact of the employee's salary (subject to ceiling) is diverted towards EPS 95.

In 1996, a provision was added to the EPS 95 rules of "Granting an option to the employer and the employee, on joint request, to contribute amounts towards the Provident Fund over and above the ceiling limits and on the actual salary."

In 2014, the government had issued a notification bringing out some major changes in the way Employees' Pension Scheme 1995 works. According to Notification No.GSR 609(E), dated 22.08.2014, from September 1, 2014, the monthly pensionable wage ceiling for the Employees' Pension Scheme 1995 was enhanced from Rs 6500 to Rs15000. The mode of calculating the average pensionable wage was also changed.

The cut-off date issue

Another para which ultimately turned out to be the most contentious was added to provide that, " The employees contributing on salary exceeding Rs. 6500 could give a fresh option to be exercised jointly by the employer and employee and continue to contribute on a salary exceeding Rs. 15000 per month. The provision provided that the fresh option was to be exercised within a period of six months from 01.09.2014 extendable by another six months at the discretion of the PF office. If the option was not exercised by the member within the stipulated period or extended period, it would be deemed that the member had not opted for contribution over the wage ceiling and the extra contributions to the Pension Fund would be diverted to the Provident Fund Account of the member, along with interest."

Several employees failed to opt for such higher pension of higher salary kind of scheme, primarily because of lack of adequate awareness around it. Court cases were fought and ultimately in 2016, the Apex Court ruled in favour of the employees citing that there need not be any such cut-off date for any such scheme or doles for the benefit of the employees. In December 2018, the Kerala High Court had quashed this Notification No.GSR 609(E) and also had set aside the various orders and proceedings related to that notification.

However, the employees that had gone up to the Supreme Court were largely from the un-exempted organizations. Subsequently, employees from un-exempted organizations too filed cases.

Delhi High Court View

Hearing one such case of the exempted firm employees, the court in its judgment says, " No doubt in our mind that there is complete and pervasive control of the EPFO over the private Trusts as regards the Provident Fund contributions, even in the case of an Exempted Establishment. The only distinction between the petitioners and the employees of the un-exempted establishments is that while in the case of the former the recipient of the contribution was a private trust and in the case of the latter, the recipient was the EPFO. This again was not the fault of the petitioners and this cannot be the basis to negate their right to them to receive higher pension on the contributions made on actual salary."

The Delhi High Court also observed that even the judgment of the Apex Court delivered in 2016 for un-exempted employees, the Apex Court had taken note of an earlier Kerala HC judgment regarding an exempted establishment that the pension should be paid on the actual salary and not on the ceiling limit.

The Delhi High Court in its 26 page judgment remarks that " All employees who are governed by the Pension Scheme will have to be treated alike as they form a homogenous group and any discrimination to one group by paying lesser pension would be clearly arbitrary, unreasonable and violative of Article 14 of the Constitution of India." Therefore, it allows the present petitions and quash the circular dated 31.05.2017. of the EPFO.

Finally, the Delhi High Court suggests the following route for the respondent of the case and the EPFO to follow:

1. Calculation process: Respondents need to cooperate EPFO and render all assistance in quantifying the amount to be refunded by each of the petitioners, with an interest rate of 6 per cent per annum.

2. Handing over the corpus to Trust: The Trust would have already remitted 8.33 per cent of the contribution of the petitioners on the ceiling amount. This means the retired employees need to first approach and handover the corpus to their respective Trust i.e. previous employer.

3. Handing over the corpus by Trust to EPFO: The balance corpus comprising of the remaining contributions on the actual salary of 8.33 per cent would be transferred by the Trust to the Pension Fund of the EPFO with all gains and the interest accrued so far.

4. Higher pension: On refund of the above-mentioned amounts, the EPFO shall calculate and disburse enhanced pension to the petitioners on the basis of the actual salaries. The arrears of pension falling due to the petitioners from the date of their respective retirement will be cleared by the EPFO and the EPFO shall continue to pay the monthly pension henceforth at the enhanced rates.

(The writer is Sunil Dhawan.)

TOP

Source

NPS Scheme: Check how your pension fund manager has performed; Scheme E Tier-I fund performance – Financial express – 27th May 2019

Several studies done in the past have shown that over the long term, equity as an asset class has generated a higher inflation-adjusted return over other asset classes such as debt, gold and real estate. National Pension System (NPS) provides the option to invest across various asset classes, including equities, under the fund option called 'Scheme E'. However, remember, the maximum investment in it is capped at 75 per cent of the amount invested.

As an NPS Subscriber of All Citizen Model and Corporate Model, one has to primarily choose few things before his or her funds are invested in NPS fund options.

As an NPS Subscriber one is required to choose the Pension Fund Manager (PFM) while registering in CRA system under NPS. Currently, the PFMs are Birla Sun life Pension, HDFC Pension, ICICI Prudential Pension Funds, Kotak Mahindra Pension Fund, LIC Pension Fund, Reliance Capital Pension Fund, SBI Pension Funds and UTI Retirement Solutions. No matter which PF manager one selects or even the default PF manager is chosen, all of them have to invest the funds as per the guidelines issued by PFRDA from time to time. As a subscriber, you have the option to change the PF Manager once in a year free of cost.

Also, one has to opt for scheme preference i.e. investment options which can be Auto Choice or Active Choice. If one opts for Active Choice, the subscriber has to allocate funds among one or more of the four Asset Classes i.e. Equity, Corporate debt, Government Bonds and Alternative Investment Funds. The four fund options available are Asset Class E, Asset Class C, Asset Class G, and Asset Class A.

Under the Auto Choice also known as Lifestyle Fund, the allocation automatically changes based on age.

How PFMs performed

Here, we look at the Scheme E (Tier I) returns generated (as on 30 April, 2019) by all the 8 pension fund managers over the last 1,2,3, 5 years and since inception. Also, the returns generated by their benchmark is shown.

The fund management is more or less index investing in NPS. If not beating the benchmark, at least the fund is expected to be in line with index returns. The top 5 stock holdings of almost all the PFMs includes – HDFC Bank, Reliance Industries, Infosys, Housing Development Finance Corporation, ITC, TCS , ICICI and Kotak Mahindra Bank with varying allocation in them.

Over the last 1 year, only 2 PFMs (ICICI and SBI) out of 8 were able to beat the benchmark, while over the two year period, there was none. HDFC Pension is the only PFM that outperformed the benchmark returns over the 3 year period, while along with UTI it again crossed the bar over the five year period.

The actual allocation in these top 5 holdings varies between 24.67 per cent and 37.23 per cent as on 30 April, 2019, which could be the reason for differences in returns.

(The writer is Sunil Dhawan.)

TOP

Source

The reasons why you should not shun investing in NPS Tier-II – The economic Times – 27th May 2019

The National Pension System (NPS) allows you to open two accounts: Tier-I and Tier-II. The latter, which can be opened only if you have a Tier-I account, has seen limited interest despite its advantages. For instance, subscribers to the NPS Tier-I account can withdraw only up to 60% of their accumulated corpus on retirement. But NPS Tier-II subscribers can withdraw as much as they want, and whenever they want. Despite this flexibility, the combined asset under management (AUM) of NPS Tier-II is just Rs 815 crore. The combined AUM of NPS Tier-I is Rs 18,973 crore.

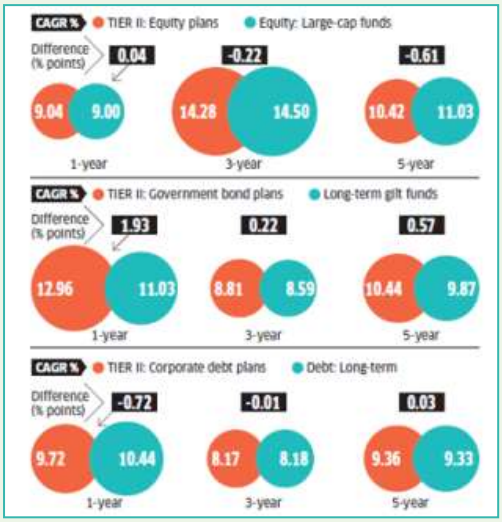
A major reason why people seem to have ignored NPS Tier-II is because of tax-related uncertainty. Some tax experts advise that Tier-II withdrawals should be treated like Tier-1 withdrawal—60% taxfree and 40% to be taxed at marginal rates. Others suggest entire withdrawal to be taxed at marginal rates. Yet others say, the tax treatment should be like hybrid debt funds—20% long-term capital gains tax after indexation benefit. "The new Budget is expected to provide Section 80CCD (1) tax benefits to NPS Tier-II investments. The tax treatment of withdrawals from Tier-II is also expected to be detailed at the same time," says Balwant Jain, a tax expert.

Ahead in debt, behind in equity

NPS Tier-II returns from debt plans have been higher than debt funds, but lower than actively managed large-cap funds.

Another reason for limited interest in Tier-II is because it is bound by some of the other restrictions applicable to Tier-I accounts. For instance, limited number of fund managers to choose from. "The number of fund managers is less under NPS and their selection is also restricted—investors can't select

one fund manager for debt and another for equity," says Harsh Roongta, a Sebi-registered investment adviser.



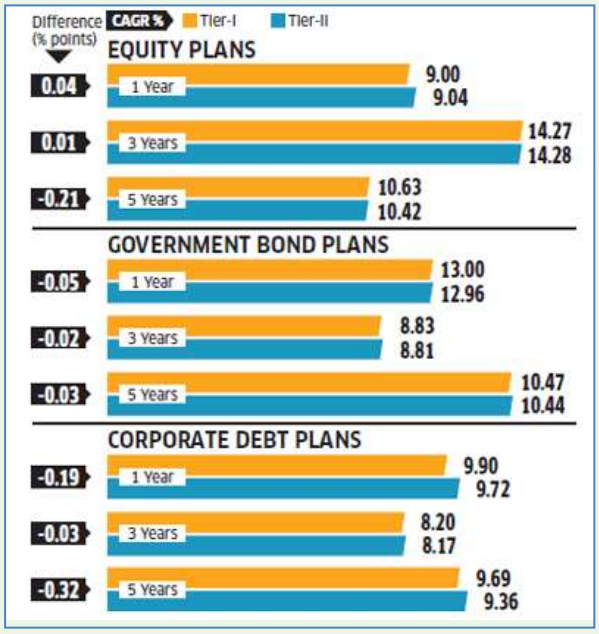
The return differential between Tier-I and Tier-II has also confused investors. Though the expense ratio of the funds under the two accounts is the same, their returns vary. Why are NPS managers maintaining separate portfolios? "Unlike Tier-I, Tier-II offers liquidity, so its portfolio is designed with this requirement in mind," says Sumit Shukla, CEO, HDFC Pension Fund. The return differential is currently low, but it can widen in the future.

Despite the issues mentioned above, investors should not shun NPS Tier-II as it offers several advantages. Tier-II is like a normal mutual fund scheme and is low-cost. "At 0.01% fund management cost (FMC), NPS Tier-II is the cheapest investment product available now and this additional annual saving should help investors in the long term due to the power of compounding," says Shukla. However, others argue that the FMC does not capture all expenses and you may end up spending small amounts at the time of investments, switching, etc.

Tier-II has generate marginally lower returns because it is managed conservatively, given its higher liquidity needs.

Source: Value Research

More importantly, investors should not look at 'absolute cost' but the 'cost effectiveness' of a product. "Low cost should not be the only criteria to select an investment product, including mutual fund and NPS. If a good fund manager is generating extra return and charging higher fees, there is nothing wrong in going with him," says Melvin Joseph, Founder, Finvin Financial Planners.



Roongta concurs: "Despite higher expense ratios, most diversified large-cap equity funds and balanced funds have generated better returns than NPS." Diversified large-cap funds beat NPS Tier-I returns across 3- and 5-year periods. However, because of lower expenses, debt plans of NPS Tier-II have fared better.

The expected additional tax benefit to be offered to NPS Tier-II is another reason to look at it favourably. "The previous government, through a cabinet note, proposed to give tax benefit under Section 80 CCD (1) to Tier-II also. This benefit will be provided to government employees and there will be a lock-in of 3-years to avail the benefit. This 3-year lock-in is comparable to 3-year lock-in period of ELSS and is lower than the 5-year lock-in for debt investments such as bank FDs," says Jain.

NPS subscribers can also switch between fund managers without any tax incidence. "They can change their asset allocation twice and also change their fund manager, once a year without any tax incidence," says Shukla. Please note that you have to pay capital gains tax, if you make similar switches in any other investment product.

(The writer is Narendra Nathan.)

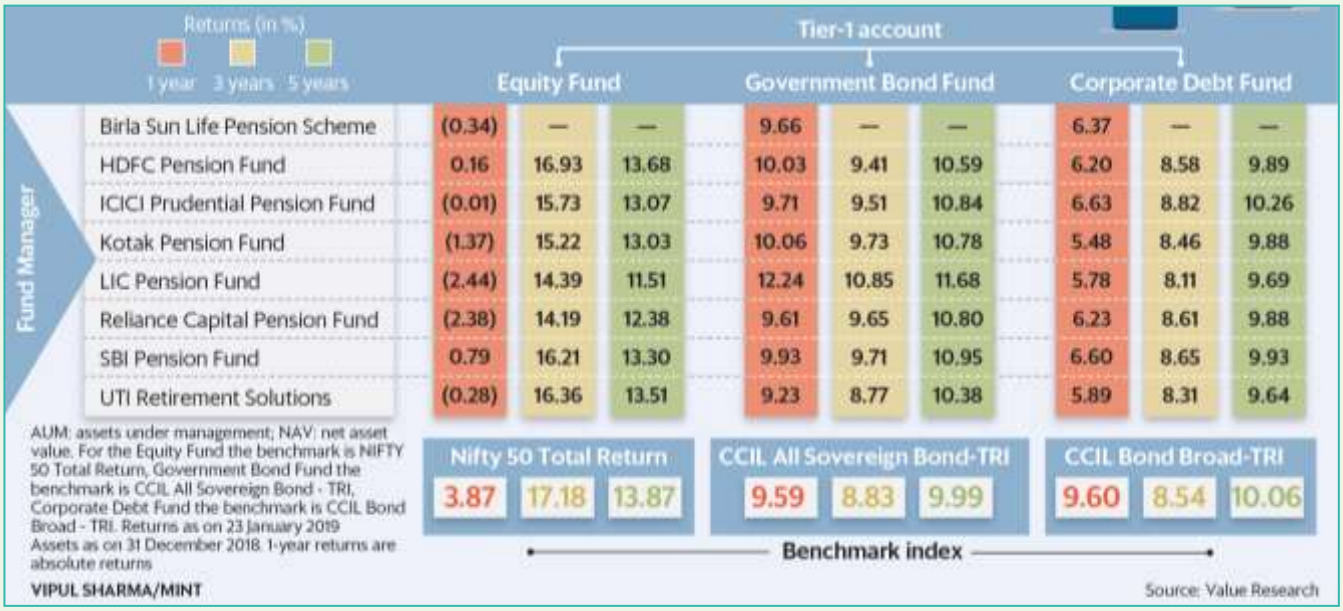
Source

TOP

How your investments in NPS are faring – Mint – 26th May 2019

There are very few retirement products that help you accumulate a retirement nest egg and one such product is the National Pension System (NPS). NPS is a market linked, defined-contribution product that needs you to invest regularly in the funds of your choice. Being a market-linked product, returns are based on the performance of the fund that you choose. There are eight pension fund managers to choose from and one of the ways to choose your fund manager is by tracking the returns.

Here is a breakdown of the performance of different funds of the private sector NPS.



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IRDA CIRCULARS

IRDAI issued terms and conditions of life products for F.Y. 2018-19.

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GLOBAL NEWS

New Zealand: Insurance pricing has become more risk-sensitive – Asia Insurance Review

Insurers are increasingly using granular data on risk exposures and historical claims experience to price risks more accurately. A consequence of this greater 'risk-based pricing' is increased selectivity, differential pricing and changes in levels of coverage for insurance contracts, says the Reserve Bank of New Zealand in its May 2019 Financial Stability Report released earlier this week.

The report says that risk-based pricing will enable insurers to make targeted responses as they change their assessments of the risks of climate change to coastal property, areas prone to flooding, and more frequent extreme weather events.

Risk-based pricing results in higher insurance costs for some, and a transfer of risk from insurers to affected households and businesses, and institutions that lend to them. This is likely to reduce the value of assets negatively affected by risk-based pricing, and weaken the financial positions of the assets'

owners. A rapid and disorderly change in the provision of insurance could also reduce competition and efficiency in the insurance market.

The impact of risk-based pricing in New Zealand is likely to be amplified by the high concentration of the general insurance sector. High concentration reduces the capacity for other insurers to insure risks affected by risk-based pricing, the report says.

Affordability

Some of the impact of risk-based pricing has already occurred. A greater appreciation of earthquake risks in New Zealand following the Canterbury and Kaikoura earthquakes has caused some insurers to change the price and coverage of some home and contents insurance contracts to better reflect the underlying risks of properties they insure. This has caused a decline in the affordability of home and contents insurance for relatively risky properties.

Currently, it is expected that a small proportion of insurance customers will face materially higher prices, and very few will be unable to obtain full insurance cover. But the precise impact on the overall availability and price of insurance is uncertain, reflecting limited information on reinsurance costs for New Zealand and insurer strategies.

The Reserve Bank is engaging with insurers and reinsurers to better understand the evolving position in more detail. It is likely that risk-based pricing will become more widespread in New Zealand over time. Owners of particularly high-risk assets should be aware that their insurance costs are likely to rise and the level of cover that they can obtain may become more limited in the future.

TOP

Source

New Zealand: Insurers' solvency ratios continue to decline - Asia Insurance Review

The solvency of the insurance sector has fallen, despite the sector being profitable, says the Reserve Bank of New Zealand (RBNZ) in its May 2019 Financial Stability Report released yesterday.

Solvency ratios have continued to decline for both life and general insurers. Some insurers should increase their solvency ratios to improve their resilience to financial shocks, adds the report.

Overall, solvency ratios have fallen for larger insurers but held steady or increased for smaller insurers.

The situation with locally incorporated New Zealand insurers contrasts with that of Australian insurers with New Zealand branches, whose solvency ratios have been increasing. This divergence is partly due to regulations in Australia that can require Australian insurers to build or maintain buffers over their minimum solvency requirements.

The Reserve Bank will consider the case for requiring insurers to maintain solvency buffers in New Zealand as part of a forthcoming review of the Insurance (Prudential Supervision) Act 2010 (IPSA). Currently, New Zealand insurers are required to maintain a solvency ratio above 100%. All New Zealand insurers, except one, are meeting their minimum solvency requirements.

CBL Insurance Ltd (CBL) is the only insurer known to be in breach of the Reserve Bank's minimum solvency requirements. CBL was placed into liquidation in November 2018. The first liquidator's report was published in December 2018 and gave a range for CBL's net liability position (i.e. capital deficit) of NZ$188m ($122m) to NZ$344m. There is still substantial uncertainty in the value of CBL's assets and liabilities, so the ultimate loss could be materially higher or lower than this range.

Following CBL's failure, the Reserve Bank commissioned an external independent report on the licensing and supervision of CBL. The report identifies lessons for the Reserve Bank from the failure of CBL and broader implications for the insurance regulatory regime. The findings of the report will feed into the Reserve Bank's future review of IPSA and help inform how the Reserve Bank supervises insurers in the future.

TOP

Source

South Korea: Medical expense ratio pushed up by ageing population - Asia Insurance Review

South Korea's medical and healthcare expenses-to-GDP ratio, which had been 4% in 2000 and 4.9% in 2005, increased from 6.2% in 2010 to 7.6% in 2017 due to rapid aging of the population, the Korea Insurance Research Institute said in a recent report.

The ratio of public funds in the expenses rose from 53.9% in 2000 to 58.4% in 2005, 60.4% in 2010 and 58.2% in 2017. The OECD average was 73.4% in 2017, reported Business Korea quoting the report.

In the meantime, the Korea Institute for Health and Social Affairs announced that South Korean households bore 33.3% of their total current health expenditure in 2016, 1.3 percentage points lower than in 2011. A lot of treatments were not covered by the national health insurance scheme until 2017.

With medical support expanding, the potential years of life lost per 100,000 population showed a significant decrease. The index indicating early death based on a potential lifespan of 70 years fell from 4,951 years in 2000 to 3,834 years in 2005 and then to 3,248 in 2010 and 2,593 in 2015.

South Korea remained the country with the highest suicide rate in the OECD. Its figure, which had been 16.6 per 100,000 population in 2000, rose to 29.9 in 2005 and 33.5 in 2010 before falling to 25.8 in 2015. It was 11.6 in the OECD.

TOP

Source

Japan: Public health insurance to cover genome testing for cancer patients - Asia Insurance Review

Japan's public health insurance system is set to cover genomic testing for cancer patients who have not responded to conventional cancer treatments from 1 June onwards, reported The Japan Times citing a recent decision made by the health ministry. Under the new inclusion, patients will only have to pay 10-30% of testing fees.

Patients eligible for the insurance coverage are those suffering from solid cancers, excluding cancers of the blood, and have not responded to surgery and anti-cancer drug treatment. Eligible patients include paediatric cancer patients and patients with rare cancers as well.

For genomic profiling, patients are required to provide tumour tissue specimens either at any of the 11 hospitals playing a major role in cancer genomic medicine or 156 other hospitals across the country. At the hospital, experts will assess which drugs will be effective for the respective patient and convey their analysis to them through the doctors in charge.

These hospitals are also required by the health ministry to submit the test's anonymised results to a national cancer research centre after receiving consent from patients. The information gathered is expected to be used to develop new treatments. Around 26,000 people are expected to use genomic profiling annually and yearly sales of such products will probably reach JPY15bn ($136m).

In December last year, the Health, Labor and Welfare Ministry approved the marketing of cancer genome profiling systems which detect gene mutations in cancer patients by analysing their tumor tissue. The fee for testing using genome profiling systems developed by either the National Cancer Center in collaboration with health instrument manufacturer Sysmex Corp or Chugai Pharmaceutical Co, would cost JPY560,000 without insurance coverage.

TOP

Source

Japan: Profitability of P&C insurers to remain stagnant despite fire premium hikes - Asia Insurance Review

Top Japanese insurance groups, while announcing earnings results for the fiscal year ended 31 March 2019 (FY2018), have said that they will raise the gross premium for fire insurance in FY2019. The premium increase is mildly credit positive, but it is not likely to be enough to turn current underwriting losses for fire insurance into profit, says Moody's Investors Service.

In a commentary headlined "Fire insurance rate increase is credit positive, but stagnant profitability will continue", Moody's says that the rate increase is driven by the revision in the advisory pure premium rate (the advisory rate) for homeowners' fire insurance filed by General Insurance Rating Organization of Japan (GIROJ) in May 2018. This revision by GIROJ increased the advisory rate by 5.5% on average, reflecting the increase in the historical insurance payouts associated with natural catastrophes and water leakages in recent years. However, the advisory rate increase does not reflect the significant insurance losses from typhoons and floods in June to October 2018.

Stagnant profitability for the fire insurance segment will continue despite the rate increase because of pricing rigidity in overall premium rates for consumer-line policies and from competition in the corporate-line market.

The pricing rigidity in the consumer-line comes from Japanese insurers' legacy fire insurance portfolio. This rate revision is only being applied to new policies and each insurer holds a large portion of legacy long-term fire policies of up to 10 years currently, and up to 36 years for policies sold before October 2015. Therefore, the rate change will only apply to a part of insurers' portfolios, and the pace of increase in overall premium rates will be slow. This is notwithstanding our expectation that top insurers will raise their pure premium rates slightly more than GIROJ advisory rates.

The top insurance groups are MS&AD Insurance Group Holdings, the parent company of Aioi Nissay Dowa Insurance (ADI) and Mitsui Sumitomo Insurance (MSI), Sompo Holdings, the parent company of Sompo Japan Nipponkoa Insurance (SJNK), and Tokio Marine Holdings, the parent company of Tokio Marine & Nichido Fire Insurance (TMNF).

Social responsibility and pricing rigidity

Social responsibility is another reason for the pricing rigidity in the consumer-line premium rate. Insurers tend not to drastically differentiate their pricing to reflect the risk of individual policies, hoping

to maintain goodwill and ensure coverage is fair for all customers. This practice would sometimes lead to consumers with higher-than-average risks purchasing policies charged at a lower premium rate in relation to the risk of the insured event. For example, insurers do not change the flood risk pricing system to one that varies according to location of the insured properties to reflect the actual flood risk at a granular level.

Improvement in pricing of corporate-line fire insurance is also difficult because of intense competition among insurers. For example, to retain customers through pricing negotiations, insurers sometimes offer low rates for clients with good loss records in, say, the past 5-10 years, even if they assess these clients to have high tail risks such as the ones with return period of one-in-30 years or more. Insurers adjust to this low price by bundling corporate-line fire insurance products with other more profitable products, like liability insurance.

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China: Life business grows faster than P&C sector from Jan-April – Asia Insurance Review

The Chinese insurance industry posted total gross premiums amounting to CNY1.9trn in the first four months of this year, representing an increase of 14.5% over the corresponding period in 2018, according to data from the CBIRC. Of the total, the personal insurance market collected premium income of CNY1.52trn, up nearly 17% year-on-year, while the P&C sector saw premium income of CNY388.8bn, up 7% year-on-year.

The details for the personal insurance market from January to April 2019 are:

Class	Gross premium CNY bn	Increase	Market share
Life	1,200	13.6%	79.1%
Accident	44	21.5%	2.9%
Health	273	34.6%	18.0%
Total	1,517	17%	100.0%

In terms of new business payments for policyholders' insurance funds and independent accounts in the first four months of this year, the total amount of new deposits increased by 35.9% to CNY511.7bn. Of this total, new business deposits for investment related funds amounted to CNY497.6bn, while new payments for investment linked plans reached CNY14.1bn.

The details for the P&C sector from January to April 2019 are:

Class	Gross premium CNY m	Market share %
Corporate property	21,100	4.68
Household property	3,600	0.80
Motor	265,500	58.95
Engineering	5,300	1.18
Liability	28,900	6.42
Surety	24,600	5.46
Agriculture	21,800	4.84
Health	43,000	9.55
Accident	18,600	4.13
Others	18,000	3.99
Total	450,400	100.00

For the whole of 2018, life insurers saw anaemic growth, posting an increase of 0.85% in premium income to CNY2.6trn, as business was affected by a regulatory crackdown on short term, high yield, universal insurance products. In contrast, P&C insurers collected CNY1.18trn in premium income, an increase of 11.5% over 2017.

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Source

Global: Insurers' underlying economic position to be unaffected by IFRS 17 - Asia Insurance Review

While the IFRS 17 accounting standard for insurers is unlikely to affect Moody's view of their creditworthiness, it may make their performance more transparent and shape their strategic decisions, Moody's Investors Service says in a report published earlier this month.

"IFRS 17 will transform insurance accounting but won't change insurers' underlying economic position," said Ms Helena Kingsley-Tomkins, AVP-analyst at Moody's. "As we already look beyond reported figures to focus on the underlying economic picture, we don't expect IFRS 17 to alter our view of insurers' creditworthiness."

The standard, set to come into force in January 2022, is designed to improve visibility of earnings and make insurance companies' performance more comparable. For some insurers, IFRS 17 will meaningfully alter reported equity and/or profit recognition patterns. However, the impact of the new standard could influence companies' product, pricing and/or investment strategies.

The financial impact will largely depend on insurers' business mix and current accounting standards. Annuity writers and traditional life insurers with exposure to policies carrying high guaranteed rates of return, particularly in Germany, Korea and Taiwan, which are reserved using historic discount rates, are most likely to report a decline in equity.

Capital largely unaffected

IFRS 17 is unlikely to affect the regulatory capital of insurers operating under regimes that tailor capital requirements to underlying risks, such as Solvency II in Europe. But in other markets, it could expose weak balance sheets and may trigger capital enhancement measures. This has already occurred in the Korean life insurance sector. In a few exceptional cases, an unexpected or outsized drop in reported equity relative to peers would increase leverage, potentially harming investor perception, and constraining financial flexibility.

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