Insurance Institute of India
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INSUNEWS

- Weekly e-Newsletter

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• Quote for the Week •

"Your beliefs become your thoughts, yours thoughts become your actions, yours actions become your habits, yours habits become your values, and your values become your destiny."

Louis D. Brandeis

INSIDE THE ISSUE

Insurance Industry

Pradhan Mantri Suraksha Bima Yojana: Insurers lose 80-100 pc on it, seek at least doubling of premium - Financial Express – 13th March 2018

Government-owned insurance companies, mainly, are incurring losses of 80-100% on the prime minister's accident insurance scheme, Pradhan Mantri Suraksha Bima Yojana (PMSBY). Compared with a premium of Rs 161 crore collected this year, insurance firms have disbursed claims of around Rs 290-320 crore. While they are planning to ask for doubling the premium levels for now — from Rs 12 per annum to around Rs 20-30 — even this may not be enough since similar insurance sold by these insurance companies can cost up to Rs 80 for a similar Rs 2 lakh cover albeit for individuals, and around Rs 45-50 for group insurance. A total of 13.4 crore persons have availed the PMSBY and, till March 5, a total of 20,249 claims were received; of these, 15,727 were settled. Launched in 2015, the insurance scheme gives a Rs 2-lakh cover for accidental death/permanent disability and Rs 1 lakh for partial disability. "In the past three years, claims from PMSBY have remained in the same range and the government had said that premium rate revision would be taken after three years," said a senior official of a leading insurance company.

The official added, "At the meeting with the ministry of finance next month, we will ask for an increase in premium to Rs 20-30 per annum. The claims ratio has remained in the same range for the previous financial year and a hike in premium rates will give some relief to us," said a senior official of a leading insurance company. Another official of an insurance firm said, "Though overall numbers look small in terms of claims, if more people participate and the claims remain at the same levels, it will hurt our industry. We hope that government understands our point of view and increases the premiums next time." The scheme, launched in May 2015, was seen as a ground-breaking step to provide affordable, universal access to personal accident cover at a nominal cost to all Indians. The premium amount has to be paid by May-end every year for renewal and the policies are linked to the bank accounts of the beneficiaries. While several private players provide cover under PMSBY, state-owned general insurers including New India Assurance, National Insurance Company and United India Insurance together command a share of 70-75%. Huge under-pricing also applies to other insurance schemes such the life insurance under the Pradhan Mantri Jeevan Jyoti Bima (PMJJBY). In the case of the PMJJBY, while LIC charges a premium of Rs 1,529 per annum to a 20-year-old for a 20-year cover for Rs 6 lakh — going up to Rs 6,273 for a 45-year-old — the PMJJBY charges a mere Rs 330 for everyone between 18 and 50. Compared with a premium of Rs 1,028 crore for life policies in FY17, its second year of operations, the claims were for Rs 1,249 crore, giving it a claims ratio of over 120%. In the case of the yet-to-be-launched health insurance scheme announced in the Budget, while the government has estimated Modicare will cost around Rs 1,000-1,200 per family per year, 30 non-life insurance firms in the country have written to the finance ministry saying the premium needs to be at least Rs 2,500 for the scheme to be viable.

Source

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Living wills not likely to impact insurance payouts - The Economic Times - 11th March 2018

The Supreme Court ruling permitting a 'living will' that specifies that a person should be taken off life support if he or she slips into a vegetative state or is beyond medical help is not likely to impact insurance payouts as most policies are bound to honour their terms after one year of issuance.

A section of senior citizens on Saturday flagged the Supreme Court's decision, which permitted a person to specify a future medical condition where life support system is withdrawn, to express concern whether death through passive euthanasia will impact sum assured under life insurance policies.

'Kin to get policy money if insured kills self within 1 yr'

A 65-year old confided about his happiness that a 'living will' can provide for passive euthunasia and end suffering during irreversible critical illness period, but was worried if his multiple life insurance policies would be affected if his end is not to be counted as normal death. "Would it not be viewed as suicide by the insurance companies to deny my children the full sum assured in case of death under these policies," he asked.

His concern was echoed on several social media networks. TOI asked independent financial consultant Mahesh Tanwar, who advises people on investments in insurance and mutual funds, about the life insurance companies honouring their commitment to pay full benefits even if they decide to equate passive euthanasia with suicide, in the worst case scenario.

Tanwar said the standard clause governing suicide in most life insurance policies at present provides - "The policy shall be void, if the Life Assured commits suicide (whether sane or insane at the time) at any time or after the date on which the risk under the policy has commenced but before the expiry of one year from the date of commencement of the policy." In such a scenario, policy holder's kin would get no money at all, he said.

He said if a person commits suicide more than a year after commencement of the life insurance policy, then the insurance company is legally bound to make full payment of the sum assured to the kin of the deceased. In the past, the life insurance policy clause used to specify a period of three years- that is no claim payment would be entertained if policy holder committed suicide within three years of commencement of the policy, he said.

However, from January 1, 2014, the Insurance Regulatory and Development Authority of India mandated the companies selling insurance policies to effect changes in their agreements to make provision for some payment to the kin even if a policy holder committed suicide within a year.

The change in life insurance agreement was applied to two categories of policies, one which is market-linked and the other, traditional life insurance policies. If a person who has taken a market-linked life insurance policy and commits suicide within one year of commencement of the policy, then his nominee would be entitled to receive 100% of the policy fund value.

This means, if a person had paid a premium of Rs 1 lakh for the first year and of which the insurance company invested 80,000 in mutual funds and kept rest for insurance cover, then upon his suicide, his nominee would get back Rs 80,000, said Tanwar.

But, in traditional life insurance plans, there is confusion whether nominee would get any money if the policy holder committed suicide within a year. While some portals claimed that after the 2014 IRDAI directive, the nominee was entitled to 80% of the premium already paid by the policy holder in the event of committing suicide within a year of commencement of the policy, Tanwar maintained that generally no insurance company pays anything in a traditional life insurance policy if the holder commits suicide within one year.

Source

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India: Insurance repositories slow to gain in popularity – Asia Insurance Review

Insurance repositories have failed to take off in a big way in the country, with insurance regulations not mandating insurers to issue policies only in electronic form. Although official data is still not available, it is believed that less than 2% of the entire industry's 30 million plus policies have been digitised, reports Moneycontrol.

A repository aims to enable customers to have paperless insurance policies. A repository account holds all insurance policies of a customer in a digitised form regardless of the different insurers from which the policies are obtained. Started as a pilot project by the IRDAI in 2014 wherein life insurers were asked to convert at least 1,000 of their existing individual policies into electronic form, the takeup has been muted.

The country's largest insurer, Life Insurance Corporation of India (LIC), has also not joined this system and has its own internal e-services portal.

Insurers are bearing the cost for digitising the policies.

"Repositories charge about INR30 (46 US cents) to INR40 for digitising a policy over and above the annual maintenance charges. This goes out of our pockets as the service is free for customers," said a senior insurance official.

Further, fearing non-payment of claims, policyholders too have sought to have both physical and digital policies. The head of operations at a mid-size private insurer said that it does not make business sense to have both physical and digital policies since it means insurers incurring double the costs.

According to regulatory estimates, digital policies would have enabled insurers to save huge costs compared to maintaining hard copy policies. About INR150-200 per policy is spent by insurance companies annually in maintaining policies in hard copy. If all the policies are digitised, they could help the industry save about INR1 billion a year.

The objective of creating an insurance repository was to provide policyholders the facility to keep insurance policies in electronic form and to undertake changes, modifications and revisions in the insurance policy with speed and accuracy. Here, the idea was to provide basic services free of cost and other policy-serving related ones at a premium.

When an insurer issues and maintains 'e-insurance policies', it has to mandatorily do so by utilising the services of an insurance repository. In segments like motor insurance, the IRDAI has said that all policies have to be issued in electronic format. For other policies, insurers have been asked to give an option to individuals in the proposal form to have a policy in the digital format.

Source

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Life Insurance

Private life insurers see slowdown in growth – The Times of India – 16th March 2018

Growth slowed down for private insurance companies with individual APE (annual premium equivalent) business increasing 11% year-on-year (y-o-y) in February. Private life insurers recorded a 28%y-o-y growth in individual APE business during the 11 month timeframe for 2017-18. The slowdown was led by ICICI Prudential Life which de-grew by 16% y-o-y due to high base effect.

However, HDFC Standard Life and Max Life have grown steadily at 22% and 33% y-o-y respectively. New business collection for the life insurance industry in APE terms went up 13% y-o-y in February. High growth was seen in group businesses of HDFC Standard Life and SBI Life, which saw robust increase in group term and group credit life segments. The average premium per policy, however, continues to increase for private players. This is largely because many private insurers have been seeing good growth in high ticket size ULIPs(unit-linked insurance plans). While LIC's (Life Insurance Corporation) ticket size has decreased as it grows its low-margin group business, the share of private insurers in this category has declined in total policy volumes to 24% from 29% in December 2017.

"Average ticket size for private players is quite high compared to LIC as they have been growing strongly in ULIPs," analysts at brokerage firm Prabhudas Lilladher said.

Though LIC's market share improved slightly to 47% during February it has declined 2% so far in 2017-18. The market share of top-five private players — SBI Life, ICICI Prudential Life, HDFC Standard Life, Max Life and Kotak Life — has improved by about 4.3% to around 69% pointing towards continued polarisation of the industry. "We note that among the top five private players the bulk of the market share gains has been captured by SBI Life and HDFC Life. We expect larger private players to continue gaining market shares, led by their strong distribution, superior brand image and efficient customer service," analysts at Motilal Oswal Securities said.

LIC's group business surged 32% y-o-y in February compared to a 17% y-o-y increase so far in 2017-18 while most private players, except SBI Life and HDFC Standard Life, have seen a decrease (13% decline so far in 2017-18). SBI and HDFC have seen strong traction in group term insurance and group credit life. Individual business accounts for 95.6% of total APE for private players compared to 83% for LICThe combined growth for the industry, declined 5.7% on a month-on-month basis in February. LIC's reliance on single premium remains high at 73%. Among major private players, HDFC Standard Life and Bajaj Allianz have relatively higher share of single premium business.

Source

New premium of life insurers up 27% in February - The Hindu Business Line – 14th March 2018

Life insurance firms reported an increase of about 27 per cent in new premium collection in February at Rs 13,698.52 crore, data from insurance regulator IRDAI showed on Wednesday.

Of the 24 life insurance firms, the new premium collection of LIC, the country's only state-owned as well as the largest insurer, was up 24 per cent to Rs 8,476.73 crore during the month.

The remaining 23 private sector players had new premium collection of Rs 5,221.79 crore in February, up 32.4 per cent from a year ago, showed Insurance Regulatory and Development Authority of India data.

Private sector players

Among the private sector life insurers, SBI Life reported new premium of Rs 709.72 crore in the 11th month of this fiscal, up 32 per cent; HDFC Standard Life witnessed a jump of 80.4 per cent in new premium at Rs 1,190.90 crore during the month.

Of the others, ICICI Prudential Life had new business worth Rs 780.79 crore, down 12 per cent from a year ago, Bajaj Allianz Life was at Rs 368.49 crore against Rs 177.51 crore a year ago and Birla Sun Life Rs 182.79 crore against Rs 142.43 crore.

Bajaj Allianz said this is the highest increase in new business premium for the company among the top players in the insurance industry. The growth was 107.59 per cent.

Source

Cumulatively, all the 24 life insurance companies' new premium collection during the April-February period of this fiscal increased to Rs 1,64,321.18 crore, from Rs 1,40,346.76 crore a year ago.

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Life insurers see positive growth in February - Financial Express – 14th March 2018

The life insurance industry continued its positive growth in the month of February as private life insurers saw individual annual premium equivalent (APE) grow at 11.4% year-on-year in February. Market leader, state-owned Life Insurance Corporation of India (LIC), saw its individual APE grow at a slower 9.3% year-on-year to Rs 2,343.2 crore in February than its private peers, showed data compiled by brokerage Edelweiss.

Even if we look at the data of the current financial year upto February 2018, LIC has registered lower individual APE at 15.4% as compared to private players, at 28%. Senior officials in the insurance industry say that, compared to the previous months there has been a slowdown across segments in February.

"While overall growth momentum seems to be moderating (partially due to base effect), we maintain proclivity towards financial savings will persist and industry will regain growth momentum," said the Edelweiss Report. It added that, higher ticket size was probably the key growth driver for private sector, implying a tilt towards unit linked insurance plans (ULIPs).

Players like Bajaj Allianz, Kotak Life Insurance, Max Life, IndiaFirst Life Insurance and HDFC Life Insurance continued to see positive APE growth.

"In the month of February most of the growth came from single premiums for both individual as well as group business. It is likely that, money might be going to Ulips for tax purpose. With equity funds being taxed at 10% we hope that numbers in March will also be strong for Ulips," said a senior official with a leading insurance company.

According to the data from the Insurance Regulatory and Development Authority of India (Irdai), first year premiums in the month of February for life insurance companies surged 27% to Rs 13,698.52 crore from Rs 10,791.68 crore in the corresponding period last fiscal.

The Edelweiss report added: "Overall growth momentum (Ind APE) softened to 10.5% YoY growth in Feb'18, post weaker growth recorded by both private players and LIC, which clocked sub-10% YoY growth (YTD growth of 15%).

Source

Having said that, divergence was seen among players – while ICICI Prudential Life and SBI Life were largely responsible for the soft growth (private growth, ex- ICICI Prudential and SBI Life, stood at >22%), Max Life and HDFC Life reported better growth."

Don't buy term insurance just to save tax, make sure it is the right cover for you - The Economic Times – 14th March 2018

To err is human, but making a financial mistake can come back to bite you when you least expect it. One such financial mistake made by people is that in their hurry to make last minute tax-saving investments, they miscalculate their insurance needs and overlooking getting a risk cover. People end up buying a life insurance policy just to avail the tax benefit that premium payments can fetch them, without considering their insurance needs.

Premiums paid towards a term insurance plan qualify for a tax benefit under section 80C of the Income- tax Act, 1961. You can claim a deduction up to Rs 1.5 lakh a financial year for the premium paid for yourself, your spouse, and your children.

But the tax benefit should not be the only factor to consider while buying an insurance plan. A term insurance plan acts as an income replacement tool for a family when the primary earner dies. The importance of having a term insurance plan is such that even financial planners suggest taking a life cover even before starting to invest for long-term goals.

Premium of a term insurance plan

All life insurance companies have term insurance plans. As term insurance plans do not have any maturity or surrender value, a buyer would more likely go with the plan that offers the lowest premium, at constant parameters such as age, term and sum assured.

And, as the premium of a term insurance plan is low compared to endowments or unit-linked insurance plans (Ulips), one may get influenced by its pricing and base the buying decision solely on the premium of the plan. However, while looking around for a term insurance plan, premium should be the last thing to look at.

If the term insurance plan has been bought with an adequate sum assured (life cover) and for the right tenure, it will help the surviving family members maintain same standard of living when the breadwinner dies.

So, to save on tax or pay a low premium, don't just buy any term plan without reading the terms and conditions. Here are a few important things one should consider while picking a term plan.

1. When to buy

It's a misconception that only married people need insurance. In fact, life insurance is a necessity for anyone who has financial dependants. So, even unmarried children where parents are dependent on them need to have adequate life cover. In addition to the basic life insurance amount, one needs to add cover as and when liabilities increase. Add cover when there is new addition to the family or when a big-ticket loan such as home loan is taken.

2. How much you need

This is one of the most important factors in the buying process. For arriving at a more realistic figure, use any of the tools available on the insurer's website or on the Internet to arrive at how much cover you need to take. Most such tools base the calculations on the 'income' that one earns rather than on the 'expenses', and due to this figures will vary. As a thumb rule, you could buy a life cover equal to at least 10 times your annual income.

3. Will one plan be sufficient?

Ideally, one single term insurance plan should be enough. However, your insurance needs are not constant all throughout your life. The requirement starts increasing once you get married, have kids and start taking loans. But once the goals such as children education, marriage are met, the requirement starts tapering. Typically, by age 60 or on retirement, most individuals are over with their financial obligations.

There are many who are unsure about their future liabilities or haven't planned them yet. One may, therefore, split the total amount of cover into one or more policies. As and when one's liabilities are over, one may drop one plan by stopping to pay its premium. Buying a separate cover for liabilities, such as a home loan, helps and can be terminated when the loan is over.

Make sure your plans don't run long because post retirement, when earnings stop and you don't have any financial liabilities left to achieve, you may still have to keep paying premiums. As a fair practice, you should disclose the details of existing plans while buying a new policy from another insurer.

4. Should a rider be added

Merely having a life cover may not be enough. A policyholder may become disabled due to an accident or otherwise, thus impacting his or her earning capacity. Failure of making timely premium payments towards the policy may render it inoperative and the objective of buying the policy will not be met. Also, there may be hospital-related costs during the tenure of the policy. Invoking the base policy may not help or may not even be allowed. And, what if one wants to enhance the coverage in an existing plan at a lower cost? This is where riders of in a life insurance plan may come handy.

Riders are additional benefits in a life insurance policy and are optional. They may or may not be attached to the primary policy. When attached, they come into play on the occurrence of a specific event and provide a financial cover over and above the basic sum assured.

Few common riders are - Accidental Death Benefit, Accident and Accident Disability Benefit, Waiver of Premium, Income Benefit on Accidental Disability, Critical Illness, and Guaranteed Insurability Option.
Adding a rider may help you customise your life insurance policy. For those who want to keep risk covers in one place or with a single insurer, such benefits are useful. One may explore such benefits from non-life insurance companies too in terms of features and premium. However, evaluate the need of each specific rider rather than opting for them merely because of low premiums.

5. Tenure

The next important factor is to fix the tenure. Few insurers offer terms up to 35 or even 40 years. Longer the tenure mean's higher premium and vice versa. Also, insuring for a longer tenure may not be the right approach if your liabilities are over early or by the time you retire.

6. Type of plan

In addition to a plain vanilla term insurance policy, insures have started offering term plans that come with increasing and decreasing sum assured and few other options. Unless, one is able to review one's needs every five years and take corrective action, a plain vanilla, with the lowest premium, will be sufficient.

7. Offline or online

Other than an insurance agent, one can buy term plans directly from insurance companies by visiting their websites or from policy aggregator websites such as Policybazaar and Coverfox.

Buying a term insurance plam online has two benefits. One, the plan costs much lower cost online than its offline version. A term plan bought online can be cheaper by 25 percent or more than its offline version from the same insurer. Two, comparing features, price and availability of the policies is easier.

However, while buying a policy online do keep in mind that since there's no intermediary, all communication has to be done directly with the insurer.

8. Which insurer

All insurance companies are regulated by the Insurance Regulatory Authority of India (IRDAI), who not only keeps a close watch on their financials but also on their solvency margin, i.e., the ability to pay up the dues when they arise.

Insurance being long-term contracts, merely looking at the claims settlement ratio of an insurer may not help much as it will keep changing over the years. Do not buy a term plan from a company which you are not confident about, irrespective of the sales pitch and the low premium.

9. Filling of form

Insist on filling up the application form on your own rather than have the insurance agent do it. This makes you aware of the things the insurer wants to know before they underwrite the insurance cover to you. Ensure that you disclose all material information such as existing ailments and current medication, family history, your smoking habits etc.

10. Nomination

Do not leave filling up the nomination for the policy for later. Further, your nominees must be aware of the insurance cover you are about to buy and should know where the policy documents are kept. One way to make sure the proceeds go to the intended beneficiaries is when the insured endorses the policy under the Married Women's Property Act, 1874 (MWP). Click here to know more about it.

Source

What you should do

Having bought a protection plan, make sure you top it up with a critical illness or a disease specific plan such as a cancer cover. Buying life insurance merely to save tax could be financially damaging. Instead, park your savings in Public Provident Fund or Equity Linked Savings Scheme for meeting long-term goals, while keeping the tax liability at bay. And keep these factors in mind while selecting a term plan.

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Life insurance: 6 steps to avoid policy purchase regrets - Financial Express – 14th March 2018

As life Insurance serves as a safety net to mitigate future unfavourable circumstances, it is imperative to know the intricate details of what the plan entails. One of the main reasons for individuals to be disappointed with their life insurance plans is when they do not fully understand the details of their coverage, thereby derailing the claims process, be in at the time of maturity or untimely death. Here are six simple ways to avoid this pitfall at the policy buying stage itself.

Have clarity on buying the policy

Before even starting the buying journey, have clarity on the life goal you plan to secure through the life insurance policy. While money is fungible, it is always good to buy a life insurance plan for a specific need. This not only gives the reason to buy, it also helps you continue with the policy for the full policy tenure. You can also assess how each of the product features is linked to the need for which you are buying, thus reducing the risk of buying something that you later regret. Though once-in-a-lifetime offers are enticing, it's a trap you should avoid at all costs. Always ask for the company authorised 'benefit illustration' customised for you and don't blindly fall for high returns simply because stock markets might have performed rather well in the last two years.

Do your own research

You must do your homework carefully and go through the product brochure and the other available information on the company's website to understand various aspects of the policy you plan to buy. While sellers are a good source of knowledge, your own research goes a long way in making an informed decision. If required, talk directly to the company representatives. Even better, ask your agent if you can speak to other customers who have purchased the same/ similar product five years ago. You do this for your property purchase, don't you?

Don't take a decision in haste

Any decision taken in haste related to financial investments is likely to be regretted later. Do not fall prey to, 'Now or never' offers or 'Last chance to grab this golden product'. In a competitive market, a consumer is spoilt for choice. You will always find customised products that cater to your specific need. A little financial prudence coupled with patience will help you make an intelligent and informed decision.

Fill the form yourself

The devil is in the details. When you get a job offer or buy property, do you sign the papers without reading? Of course not. So why would you sign your insurance papers without reading it? It's a common practice to sign only in places pointed out by sellers. When you fill the details yourself, you understand the nitty-gritty of the policy, the inclusions, exclusions, grace period, surrender value, and other vital details. It minimises chances of error and helps you fully understand the product you wish to buy. Also, closely look at the medical details asked in the form. Concealing information related to your health can lead to claim rejection at a later date, defeating the very purpose for which you bought the policy.

Check the product name, type

There are multiple policies sold by life insurance companies—term plans, ULIPs, and traditional plans. There are minor product variations under each category. For example, when you procure a home loan, a traditional endowment policy may not serve your purpose. Instead, you may need a policy customised for loans available with your mortgage loan provider. Therefore, always check the name and type of the product while filling out the form.

Wait for a direct call from the insurer

Most life insurance companies call you to verify your understanding of the key terms and conditions of the policy. This is done to ensure that you have understood the policy, its benefits and various terms and conditions. If you feel that the policy sold was different from what the seller explained, you can cancel it. In any

case, there is a 'freelook period' after you receive the policy document, during which you can chose to return it within 15 days if it does not meet your expectation.

Being aware is the best way to protect yourself against future regrets while purchasing a life insurance policy for the long term. Don't fall for 'too-good-to-be-true' products and take an informed decision by carefully going through the policy brochure.

Source

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A low-cost Ulip that can only be bought online – Mint – 14th March 2018

Unit-linked insurance plans (Ulips) are again gaining traction and insurers are trying to get your attention by reducing costs. Max Life Insurance Co. Ltd also launched a Ulip called Max Life Online Savings Plan. As its name suggests, it is available online. Max Life has waived some of the charges. Here are some details.

It comes in two variants: a Type-1 Ulip that pays higher of the insurance cover or the fund value on death of the policyholder during the policy term; on maturity policyholder gets the fund value.

The Type-2 plan works like a child plan. On death of policyholder, the nominee (child) gets the insurance cover; future premiums are waived off and on maturity the nominee gets the fund value. Regulations mandate a minimum payment of 105% of all the premiums paid on death for both the variants.

In the Type-1 plan, depending on your age, you can choose a sum assured ranging from 10 times to 20 times the annual premium. The younger you are, higher is the sum assured available.

In the Type-2 plan, sum assured is fixed at 10 times the annual premium. On death of the policyholder, nominee will also get guaranteed monthly payouts that are 1% of the sum assured. This will be for a minimum of 3 years and maximum of 10 years. For instance, if the policy term is 15 years and death occurs in 3rd year, insurer will pay for 10 years (not 12). But if death occurs in 14th year, insurer will pay for at least 3 years (not just 1 year): monthly income for a year and the remaining instalments as lump sum on maturity.

There are five investment funds to choose from, of which three are equity funds. You can invest in any of these or go for a duration-based strategy. In this strategy, you allocation starts equity heavy, and the equity portion is tapered as maturity nears. This plan is currently being offered only on Policybazaar.com, a web aggregator. "It is designed for goal-oriented and self-reliant customers. Online aggregators are an important step in the (buying) decision and hence the plan is currently available on Policybazaar.com," said Manik Nangia, director marketing and chief digital officer, Max Life Insurance.

How it works

Max Life has waived off the premium allocation and administration charge on this Ulip. This charge is deducted from the premium, while policy administration charge deducted from fund value.

"In fact, even the fund management charge is not a flat 1.35% that most other Ulips charge for their equity funds. It's 1.25% for equity funds and 0.90% for debt funds," added Nangia. Insurance charge will depend on your age, sum assured and the variant chosen.

It is deducted from fund value. If a 35 year old buys the Type-1 plan for a term of 25 years, annual premium of Rs1 lakh and sum assured Rs10 lakh; then assuming growth of 8%, the maturity corpus would be Rs61.53 lakh. This is a net return of 6.37%.

Should you buy?

While the costs are competitive, there are cheaper plans in the market as more insurers have begun shaving costs. But there are a few concerns. "Insurance cover for the premium paid is inadequate. Also, for investment, equity mutual funds tend to give better returns,"said Shweta Jain, founder, Investography Pvt Ltd, a financial planning firm. "A Ulip makes sense for people who want the convenience and discipline of investing regularly," she added.

With the re-introduction of long-term capital gains tax on equity investments, Ulips have come under the spotlight because they are currently not affected by this tax.

Source

However, it is important to understand that the structure of a bundled plan like Ulip is not flexible. So make sure that you understand the plan and are prepared to stay in it for the long haul.

8 charges in Ulip that one needs to know - The Economic Times – 12th March 2018

Proposal to tax the long-term capital gains (LTCG) arising out of transfer of equity shares and mutual fund has brought the focus back on unit linked insurance plans (Ulip) because of the tax advantage they will now enjoy.

Ulip is considered to be a mutual fund wrapped with an insurance cover. But, unlike a mutual fund where there is one single consolidated total expense ratio (TER) to look at, Ulips have a long list of charges.

In a Ulip, the entire amount paid as premium is not used to purchase units. The insurers deduct certain charges and fees before allotting units. The remaining premium amount is invested in various asset classes such as debt, equity or both (called fund options) depending on policyholder's choice.

The structure of charges may vary among insurers and plans, but broadly here are the different types of fees and charges.

I. Premium Allocation Charge

Premium Allocation Charge (PAC) is deducted as a fixed percentage of the premium received and is usually charged at a higher rate in the initial years of a policy. This charge normally includes initial and renewal expenses and the commission expenses of the intermediary.

PAC is a certain percentage that is deducted from the premium (even on top-up, additional premium) and the balance is used to buy units at the prevailing net asset value (NAV). For example, if the PAC is 12 percent, then on a premium of Rs 1 lakh, Rs 12,000 gets deducted and the balance of Rs 88,000 is available for allocation into the fund options.

PAC is charged on the premium paid and hence it is said to be front-loaded. It is charged even on the renewal premium paid, however, the quantum tapers off in later years and may be charged only for the initial 5-7 years of the policy. Thereafter, the PAC could be nil, which is the case with most Ulips purchased online.

PAC may even vary depending upon whether the policy is a single premium plan or regular premium one, the premium amount, premium frequency (i.e., monthly, quarterly, yearly) and payment mode.

II. Mortality charges

These are charges to provide for the cost of insurance coverage under the plan. Mortality charges depend on a number of factors such as age, amount of coverage (sum assured) etc. and are deducted on monthly basis. This charge will be deducted proportionately from each of the fund(s) you have chosen.

III. Fund management charge

Fund management charge (FMC) is the fee charged by the insurance company for managing various funds in an Ulip. It is levied for management of the funds and are deducted before arriving at the NAV. The FMC is adjusted from NAV on a daily basis. The maximum allowed is 1.35 percent per annum of the fund value and is charged daily. Generally, insurers levy the maximum allowed in equity funds, while the charge on non-equity funds are lower.

IV. Policy administration charge

As the name suggests, this is a fee levied for the administration of the policy and is charged on monthly basis by cancellation of units from all the funds chosen. This could be flat throughout the policy term or vary at a pre-determined rate.

Ulip charges

Type of charge	How it is charged	Frequency of deduction
Premium Allocation Charge	Fixed percentage of the premium	As and when premium is paid
Mortality Charge	Depends on age, sum assured	Monthly basis
Fund Management Charge	On fund options (before declarying NAV)	Daily basis
Policy Administration Charge	Fixed or percentage of fund value	Monthly basis
Partial withdrawal charge	Flate fee	Transaction wise
Fund Switching Charge	Flate fee	Transaction wise
Premium Redirection Charge	Flate fee	Transaction wise
Premium Discontinuance Charge	Flate fee	Transaction wise
Overall impact of charges	Term less than or equal to 10 years : RIY not more than 3% at maturity	
	Term more than or equal to 10 years : RIY not more than more than 2.25% at maturity	
RIY: reduction in yield (reduction between gross and net yields)		

V. Partial withdrawal charge

Ulips provide partial withdrawal of funds. Some plans offer unlimited number of partial withdrawals while few may restrict it to a 2-4. Such withdrawals may be free up to a certain limit and then may have a cost of say Rs 100 per withdrawal or may be free for any number of withdrawals.

VI. Fund switching charge

Moving funds or investments between options is called switching. Generally a limited number of fund switches may be allowed each year without charge, with subsequent switches, subject to a charge of say Rs 100 or Rs 250 per switch. These charges may also be deducted by cancelling units proportionately from each of the funds you have chosen. Some insurers may charge lower switching fee if it is done online.

VII. Premium redirection charge

As a policyholder, one may be putting the entire premium in, say, fund A of the Ulip. Even the future premium will be added to that particular fund. Premium redirection allows you to redirect your future premiums payments into a different fund option, say, Fund B. This redirection of premium payments will not have an impact on your investments made in Fund A.

Generally, there is a cap on the number of times you can redirect your premium payments free of cost, after which it will be subject to a charge of say Rs 100 or Rs 250 per redirection. Similar to switching, redirection done online can come at a lower cost.

VIII. Premium discontinuance charge

Upon discontinuance of premium payments (in the initial five years), your money will be locked in a Discontinuance Policy (DP) Fund after deducting the discontinuance charge (DC) in the policy. If the annual premium of a policy is more than Rs 25,000, the maximum DC can be Rs 6,000, Rs 5,000, Rs 4,000 or Rs 2,000 in the 1st, 2nd, 3rd, 4th policy year, respectively. For a lesser amount, it will be Rs 3,000, Rs 2,000, Rs 1,500 or Rs Rs 1,000 in the 1st, 2nd, 3rd, 4th policy year, respectively. In case the policy is discontinued from the 5th policy year, there is no surrender charge.

During the period when funds lie in the fund, the insurer may apply a fund management charge which cannot exceed 0.5 percent of the fund value. The money lying in the DP fund will continue to earn interest as insurers have to provide a minimum guaranteed return which would change from time to time. Currently, DP funds are providing interest of 4 percent per annum. The DP funds will be paid out upon the completion of the lock-in period of five years.

Overall impact of all the charges

The effective impact of all the above charges is, however, capped by the regulator. As per the Insurance Regulatory Development Authority of India (Irdai) guidelines, the net reduction in yield (RIY) for policies with term less than or equal to 10 years shall not be more than 3 percent at maturity. And, for policies with term above 10 years, the net RIY at maturity shall not be more than 2.25 percent. The yield, however, is to be calculated without taking into account the mortality charges.

Ulip charges: A sample illustration

Age	Annual Premium (In Rs)	Premium Allocation Charge (In Rs)	Mortality Charge (In Rs)	Policy Admin Charges (In Rs)	Total Charges (In Rs)
30	100000	3000	1300	360	4660
31	100000	2000	1355	360	3715
32	100000	2000	1490	360	3850
33	100000	2000	1540	360	3900
34	100000	2000	1680	360	4040
35	100000	0	1710	360	2070
36	100000	0	1790	360	2150
37	100000	0	1850	360	2210
38	100000	0	1900	360	2260
Assumptions: Premium Allocation Charge of 3% in the first year and 2% for next four years;					
Mortality Charges for 30-year-old, for a sum assured of Rs 10 lakh;					
Policy Admin Charges of Rs 360 per annum.					
Taxes are not considered. Only a sample illustration. Type II Ulip considered (death benefit equal to sum assured and fund value)					

Source

General Insurance

'Digital channel may provide personalised car cover pricing' - The Economic Times (Mumbai edition) – 12th March 2018

Maruti and Hyundai are not only the largest car makers but also are among the top performers on claims outcome whereas Skoda and Volkswagen show a higher frequency to claim and cost more per claim in the online segment, according to a report.

Insurers may start redefining the way car insurance is underwritten in the market, by loading up premium where the experience is bad. A report by PolicyBazaar show that Skoda and Volkswagen were both above 100% on loss performance and had an equally high frequency on claims. In fact, for Volkswagen, one out of every three vehicles made a claim in 2016-17 which is very high considering that average vehicle under consideration was either a renewal or rollover.

"Cost per claim is high in case of Skoda and Volkswagen because the spare parts are expensive," said Vaidyanathan Ramani, head of products & innovation center, PolicyBazaar-.com. Around 3 lakh vehicles were studied to arrive at the conclusion. This report provides a platform to enable insurance companies to underwrite car-owners rather than the cars, as has been done in majority of the market. "With IoT, social media integration, AI and other digital innovations taking over our lives, we expect the digital channel to provide personalised pricing, coverage and offers for car owners in future," said Ramani.

Motor insurance constitutes a Rs 20,000-crore market, of which the digital channel contributes to 5% of the sales. Maruti and Hyundai were the largest two portfolios contributing 46% of total business together. Honda, Ford and Volkswagen contributed another 20% while the others contributed the rest. According to the report, SUV customers tend to show better claims behaviour than conventionally known.

The SUVs and mini-SUVs showed a good and profitable loss performance across all different models – Mahindra, Honda, Toyota, Maruti and Hyundai and loss ratio for a significant majority of these models remained at below 60% levels leaving large margins for insurance companies. Among sedans, Corolla Altis and hatchback Etios Liva showed high loss ratio of over 100% in the online motor insurance segment. Loss ratio is the ratio of total losses incurred in claims and adjusted expenses over total premium earned.

The report talks about segmentation of claims behaviour by geography, car brand, by no claims bonus, fuel type, vehicle age and car type. Consumers in South and West India are less likely to claim and they claim less amount and Karnataka, Andhra Pradesh, Maharashtra are the top-3 in terms of performance. "If a car owner has claimed in the previous year, he is more likely to claim again in the current year," the report said.

Source

Back

Health Insurance

Parliamentary panel red-flags government's ambitious healthcare scheme - The Economic Times – 13th March 2018

The Modi government has released less than half of the budgeted allocation for health insurance of poor families in fiscal 2017-18, even as it promised to step up coverage with the proposed launch of what is called the world's largest government healthcare programme. The revenue allocation of Rs 975 crore for the Rashtriya Swasthya Bima Yojana (RSBY) was reduced to Rs 565 crore and, as the year progressed, the actual

release was just Rs 450 crore -- less than half of the budget estimate, according to a parliamentary panel's report. "Funds as central share of premium under RSBY of approximately Rs 450 crore were only released for such states that submitted their proposal during the year 2017-18," said the Parliamentary Standing Committee on Health and Family Welfare in its report.

As for the reason for reducing the budgeted allocation, the panel quoted the Department of Health and Family Welfare, saying: "This ministry had moved a proposal for another scheme with enhanced cover of Rs 1 lakh per family.

"However, this proposal is still pending with the cabinet. Therefore, such states that were waiting for the new scheme to be launched did not submit any proposal and meanwhile stopped implementation of RSBY." Even the amount of Rs 25 crore allocated for capital purposes in 2017-18 for setting up office premises for the proposed scheme with enhanced cover of Rs 1 lakh remained unutilised during the period as the cabinet approval for the scheme remained pending. The money was surrendered.

The RSBY provided a limited coverage of only Rs 30,000 and there was a proposal to increase it to Rs 1 lakh. While the government had difficulties in implementing the healthcare scheme, it announced the launch a bigger healthcare programme in its Union Budget for 2018-19 last month.

The proposed National Health Protection Scheme (NHPS), which would subsume RSBY, would cover 10 crore poor and vulnerable families, and the coverage is further enhanced to Rs 5 lakh per family per year. However, the Parliamentary Standing Committee has warned of possible failures.

The committee reported that the enrolment in RSBY was quite low. "Only 57 per cent of eligible are enrolled and less than 12 per cent of the eligible persons got their hospitalisation covered through RSBY."

Citing a comprehensive review of various studies on RSBY, the panel said that in a majority of states (eight out of 14) there was an increase in out-of-pocket expenditure related to RSBY, while only two of 14 studies showed reduction in expenditure.

It further noted that many states have opted out of RSBY in favour of state-run schemes. "The government should form a committee to analyse the failures of RSBY and ensure that inadequacies plaguing the operation and implementation of RSBY are not repeated."

The panel observed that the new scheme is just a modification of the earlier one as more than half of the target beneficiaries proposed to be covered under the NHPS were already covered under existing government supported schemes. "What would indeed have been a step forward is if it covered out-patient treatment as well, but that is lacking," said the Parliamentary panel.

Source

Back

Health insurance a must for today's women - Financial Chronicle – 12th March 2018

Adequate health insurance is another step towards empowering the women who support homes and companies alike.

IN the 21st century women are more empowered than ever. So why should they be dependent on their spouses or parents for money-related decisions?

On the surface, the modern day woman appears more powerful than ever before – strong, career-orientated and independent. Yet when it comes to their financial situation, it appears they are increasingly exposed to difficulties. That's the verdict of a new survey by the Insuring Women's Futures, a programme set up by the Chartered Insurance Institute (CII), which has called upon the insurance and financial sector to unite to help improve women's financial resilience.

Today, just 20 per cent women are covered by health insurance in India, says the survey. Less than one-third (29 per cent) of households have at least one member covered under health insurance or health scheme shows the National Family Health Survey.

On the occasion of the international women's day (March 8), let's throw some light on how and why women should buy health insurance.

Penny wise, pound foolish: Women homemakers or stay-at-home moms may think it's inappropriate for them to buy health insurance as they don't earn, but the cost of not having health insurance is colossal. In India, women are more at the risk of heart diseases today than before.

The 3-year long Saffola life study, India's largest study on risk factors causing heart disease, revealed that three out of every five women respondents from the urban India were susceptible to cardiovascular disease risk due to the sedentary lifestyle and wrong food habits. It is astonishing to note that this high risk of heart disease sets in as early as 35 years of age in women.

For women between 35 years and 44 years, risk of cardiovascular disease is high. Even if you survive the heart attack or a stroke, it could have some life altering implications like being paralysed or disabled permanently.

The cost of ongoing treatment could wash away your family's savings. Hence, women should not only opt for health insurance but also select optional covers like critical illness covers suited to their age and needs.

Benefits of buying insurance early: The earlier in life, women buy health insurance the better it is, as buying insurance is cost-efficient while one is young and free from medical complications.

The premium is lower and the policy offers comprehensive coverage in comparison to a policy purchased at an older age. Most health insurance companies have an upper age limit for entry to these policies, which means one would have limited options, as they grow older.

Tax benefit: The cherry on the cake from purchasing health insurance is the tax benefit. Payments made towards health insurance premiums are eligible for tax deductions under section 80D of the Income Tax Act. Women less than 65 years of age can claim a deduction of up to Rs 25,000 for the health insurance premium paid for themselves, or their spouse, children or parents.

Lifestyle: Women today are running their own business or climbing the corporate ladder rapidly. Women today lead some of the largest banks in India. Busy corporate lives combined with managing their homes may lead to lifestyles that lack proper exercise.

Women are today as susceptible to eating tasty but unhealthy food as men just because they are too busy or feel the need to unwind with a drink and food at a restaurant. It has been observed that sedentary lifestyles have led to an increase in the occurrence of many diseases related to heart and lungs, claiming lives at a young age.

It is a sad truth that health insurance is now no more required only for elderly women. Young women too don't have a choice between a healthy lifestyle and health insurance. If the stress doesn't get you, the pollution will. Today's youth is vulnerable to a number of diseases owing to higher pollution and excessive stress in their professional and personal life.

Maternity: As women have become increasingly involved in building their own businesses or corporate careers, there has been an increasing trend to plan their family in their 30s or even later. This tends to increase the ratio of caesarean deliveries to normal deliveries, especially in metropolitan cities.

That is why many women are opting for health plans that offer maternity cover. Maternity plans in general have a long waiting period; hence having a health insurance from an early age can only be a boon in such situations.

There are various health insurance products available in the market, some of which specifically cater to special needs of women. Though not all companies offer women specific products some policies provide extra benefits like maternity benefits.

Thus make sure that you buy a basic health insurance product that covers hospitalisation. Also look for availability of critical illness covers especially for illnesses that women are more prone to. It doesn't matter if you are a stay-at-home mom or a working woman; a health insurance cover is a must as cost of managing hospitalisation is the same irrespective of your working or marital status.

Women may have shattered the glass ceiling; but still have a long way to go regarding health insurance. They need to view health insurance as an absolute necessity like a health investment. Owning adequate health insurance is another step towards empowering the women who support homes and companies alike.

Source

Is the National Health Protection Scheme good public policy? – Mint – 12th March 2018

India recently announced an ambitious plan called the National Health Protection Scheme (NHPS) to provide government-sponsored insurance to roughly 500 million people or nearly 40% of India's population. Since the announcement, there has been much debate about two issues. First, does this plan make sense? Second, if it is a good idea, what should the design of NHPS look like? In this op-ed we use insights from our prior studies and those of other experts to inform the debate on both of these questions.

So, is the NHPS a good idea? Definitely yes. There are several reasons. First, India under-invests in the healthcare of its citizens and this is affecting the health and financial well-being of Indians. Out-of-pocket payments for healthcare services are very high in our country (about 70%, according to the National Sample Survey Office, 2014), which causes impoverishment to nearly 7% of our population. Health-financing policy directly affects the financial protection of people when direct payments that are made to obtain health services do not threaten their living standards. So the NHPS should be considered a significant move towards universal health coverage.

Second, while not all insurance programmes are successful, there is sufficient evidence that if implemented well, insurance can save lives and improve financial well-being. For example, one study conducted a rigorous evaluation of the government health insurance scheme in Karnataka called Vajpayee Arogyashree Scheme (VAS). In February 2010, the state government offered VAS to below poverty line (BPL) residents only in the northern part of the state, the scheme was later implemented statewide.

Researchers took advantage of the arbitrary boundary in early implementation of coverage to compare outcomes in neighboring villages on either side of the line. In particular, they conducted surveys and compared outcomes in neighbouring villages on either side of the boundary drawn between the communities chosen for early versus late implementation.

Since the eligibility boundary is arbitrary, early and late implementation villages located just above or below the eligibility threshold are likely to be similar and differences in outcomes across these villages are likely due to differential access to VAS. The study found that VAS lowered mortality for covered conditions for BPL families and erased rich-poor disparities in mortality rates.

Most of this reduction was due to fewer deaths from cancer and cardiac conditions, which account for the bulk of VAS claims. They found that people covered by insurance were more likely to seek healthcare for their health issues and symptoms (such as chest pain), had better access to tertiary care hospitals, and had better post-operative outcomes likely due to seeking care at higher quality hospitals. They also found that insurance lowered out-of-pocket medical costs and lowered the chances of having catastrophic expenditures that are likely to push people into poverty.

Third, existing evidence shows that providing insurance to the poor not only saves lives but is also "cost-effective". That is, it provides good value for money as the benefits of insurance far outweigh the costs. However, cost-effective health coverage must cover primary care.

This is where the second feature of Ayushman Bharat Programme—creation of 150,000 wellness centres across the country—is a very significant and welcome announcement. Sub-centres (and primary health centres) are the first line of contact of citizens to the public health system in India. Strong primary care is fundamental to keeping overall access to healthcare equitable and affordable in the country.

Our biggest constraint to making this happen is not shortage of capital or infrastructure, but an acute shortage of human resources. Most public healthcare facilities (primary, secondary and tertiary) have significant shortage of doctors, nurses and other health workers, often higher than 50%.

Now that we have established that NHPS is likely a step in the right direction, how do we ensure that the programme is a success? The devil is in the detail: we need to pay attention to both the design of NHPS and its implementation. We offer some guiding principles.

Make insurance easy to use

Insurance that is difficult to use will not be used. Therefore, we need to streamline both the enrollment process and access to care once enrolled. The number of forms people face to enrol in NHPS must be minimized. Aadhaar makes it easy to verify eligibility and enrol. Maybe all you need is Aadhaar and no other

forms or hassles to enrol. For this, Aadhaar should be made readily available to demographics where it does not exist. This would require continuous and active collaboration between ministry of health and family welfare and Unique Identification Authority of India (UIDAI). In the case of children, the UIDAI authorities should take a more proactive approach and increase their coverage—as of today, data shows that of all the Aadhaar numbers issued so far, less than 5% are for those under five years of age, which is a gross undercounting of children.

Once enrolled, access to care should be provided where people live. This is a challenge in rural India but can be addressed with innovative models. For example, In Karnataka, health camps organized by super specialty hospitals were successful in improving access to care. Hospitals in Bengaluru would send cardiologists and other specialist to camps in villages. Patients identified as needing additional care were offered free transportation for patient and companion in Bengaluru. Other models are also being piloted, such as telemedicine in Uttar Pradesh where patients at primary health centre are connected to specialist doctors in Andhra Pradesh for virtual OPD care.

Target low-income populations

A programme financed by public money needs to conserve resources. Therefore, we should provide government sponsored insurance only to those who cannot afford insurance on their own. Existing coverage data shows that while private health insurance is largely concentrated among the urban richest quintile in India, public health insurance is more equitable, covering bottom quintiles of urban and rural population of the country. "Mission creep" or mis-targeting, however, is a significant threat as we witnessed in the case of Aarogyasri, where nearly 80% of Andhra Pradesh's population reported having coverage while the scheme was exclusively aimed at population below poverty line.

This is why the Aadhaar platform becomes fundamental to enrolment to the NHPS. Also evidence from prior studies suggests that insurance has much larger effects on health and financial well-being for the poor compared to the rich. In addition to targeting the poor, insurance should target health conditions where disease burden is high and effective interventions are available but underused.

Contract with private hospitals and clinics

Nearly 75% of out-patient department care and 55% of in-patient department care in India is exclusively from the private sector. Therefore, private hospitals and clinics provide care to a large fraction of the population and they need to be part of NHPS. Yes, private hospitals will try to exploit NHPS. But the solution is not to exclude them but to monitor them and create the right incentives for them. There are several options. First, not all hospitals should be eligible for NHPS. Only hospitals that meet certain quality standards should be allowed to serve NHPS beneficiaries.

Quality should be measured not only by the infrastructure available at the hospital but also by actual patient outcomes achieved. Second, NHPS should institute prior authorization for expensive medical procedures and surgeries. NHPS doctors should review the medical records of NHPS beneficiaries to make sure that the surgery in medically warranted and meets evidence-based guidelines.

Third, NHPS should reimburse hospitals using "bundled payment" so that the hospital receives a fixed amount per episode of care that covers all services provided by the hospital. This lowers incentives for the hospital to provide care just to make more money. The bundled payment can also be tied to quality metrics, creating further incentives to improve quality of care.

Use data to learn and evolve

The NHPS will have access to health information of 500 million people. This is an unprecedented amount of data and if curated well, it can have far-reaching applications. It can be used for comparative effectiveness research or understanding which treatments work in the real world rather than just in clinical trials. Treatments and interventions can be highly contextualized to local conditions. It can be used to advance personalized or precision medicine. That is, tailoring treatment based on individual genetic or other characteristics.

It can be used to improve the health system and understand how different delivery and financing designs affect care outcomes and costs. It can be used to improve transparency by providing information on quality of care provided by different hospitals or clinics in India.

Tracking the NHPS will be extremely important to set priorities and shape future health policies in India. In a large and diversified country, health needs differ from state to state, and, within a state, can vary greatly from one district to another. Good disaggregated measures of health outcomes will become the basis of framing and assessing future health policy.

In spite of the best efforts of previous governments, there is little or no evidence on whether past health policies have had the intended effects. There is little political pressure on elected representatives to address health issues, largely abetted by lack of good local health data.

Of course, this disproportionately affects the weaker and vulnerable sections of society – women and children – far more. A well run NHPS has the potential to become the cornerstone of India's healthcare needs for several future generations.

Source

Back

Insurance Bureau building Aadhaar-like database for hospitals: Kunnel Prem - Business Standard – 12th March 2018

Kunnel Prem, chief executive officer of the Insurance Information Bureau of India (IIB), tells Mayank Jain on what they're doing. Edited excerpts:

What are your objectives?

In the early 2000s, the industry had opened up and Irdai (Insurance Regulatory Development Authority of India) was collecting a lot of data. At that point, the chairman of the regulator felt data from both life and non-life insurance had to be handled in a more efficient manner. That's when Irdai promoted this body, in 2009. It was made a non-profit society in 2012.

The objective was to support the industry with sector-level data and provide key inputs to the regulator to assist in policy making. The regulator, under the mandate of the IRDA Act, advised all insurance companies to submit data in specific formats on policy and claim levels.

How is this data on policies and claims being used?

First, we are a central repository of data. If the regulator wants data while making a policy, we provide it. We, thus, support the regulator in its work. We also provide benchmark rates for the industry. We have to give back insights to the people providing us the data, the insurance companies. We provide them insights through services, reports and customised data. Each insurance company has own data but they would not be privy to what is happening at the sectoral level. We provide this. A company would also like to know how it fares in terms of sector parameters.

Are these paid services?

Some are annual reports, given free of cost. And, bespoke reports that insurer companies ask us for, which are charged. These reports are based on specific products or regions they are looking to analyse.

How much demand do you see for this data, with insurance penetration still very low?

Data is very important in all sectors, not only this one. It serves a lot of purposes for insurance companies. In life insurance, we look at the death experience or mortality, and see how and when people are dying. We look at companies' strategy, their product profile, claims experience or any leakages and assist the regulator to fix these. Also, for instance in motor insurance, a lot of vehicles get registered every day. When you match the vehicle registration with motor insurance, you get a mapper of uninsured vehicles. This is given to law enforcement agencies and this also helps to create the needed insurance. Both the government and law enforcers are committed to get this data through the exchange of information on registered vehicles.

IIB is also building a database on hospitals. What is the aim?

This initiative is called ROHINI – Registry of Hospitals in the Insurance Network. Irdai issued guidelines in July 2016, mandating all hospitals in the insurance network. Hospitals are provided a unique identification number, with the geographical coordinates. So, hospitals under the system can service cashless, reimbursement and other claims with their insurance providers. Initially, about 32,000 hospitals were on-boarded free on the network.

Later, it was stated they should renew their subscription every year, paying a small fee. After feedback, we switched to a once in three years renewal. We now charge a hospital Rs 2,750 for three years.

If a hospital doesn't have this unique ID number, it can't service insurance clients?
This is something Irdai has to look into. We are only a registering authority here but the guidelines hold that anyone who supports insurance claims must be registered with the ROHINI database. As of now, the project also needs to be enhanced quite a lot. We need to provide value to the hospitals and stakeholders. We need to transfer records digitally, to help faster processing of claims. There's a lot of scope for fraud, which can be reduced by working entirely on this digital platform. In its present state, ROHINI is only being used for registration, generating the unique number and for hospitals to participate in the insurance claims system. One could say it is like an Aadhaar (the citizen identification system) for hospitals — there's no scope for a fictitious hospital.

How many hospitals are due for renewals currently and why are they not renewing their ROHINI subscriptions?
Around 40 per cent of hospitals have renewed their subscriptions. Total hospitals on-boarded have gone up to 38,000. Everyone in the insurance network is registered. Renewal is the problem. We have done a lot of follow-up on those not renewing their subscription. We have eased the process to once in three years. Insurance companies and TPAs (third-party administrators) are making their effort. Frankly, hospitals should also understand the value they are getting from registering. We are working on enhancing our value proposition.

Are you also looking to align with ModiCare (new government scheme for health insurance) in some way?
We have some data on the Rashtriya Swasthya Bima Yojna (RSBY) but there are data sharing issues with all government departments. There is an initiative by the ministry of health and family welfare, where they are trying to create a common repository of all health care facilities. We have been asked to be part of the group. Deliberations are going on.

Is IIB covered by the Right to Information Act?
No. We operate under Irdai.

What are your future plans? The industry needs a lot of real-time services. We have proposed some; one service has been implemented. If someone approaches an insurance company with a vehicle claim, the company has to depend on their word on whether he has taken a claim before or not. We help the industry to understand, using identification, if there has been a claim or not. This helps them to avoid giving no-claim bonuses to the wrong parties. Many leakages take place because of wrong declarations. We are trying to provide services for risk mitigation and fraud prevention. Frauds, both organised and unorganised, are increasing across the country, across insurance products.

Source

Back

Crop Insurance

Telangana proposes Rs 5L insurance cover, Rs 12,000 crore support scheme for farmers - The Economic Times – 15th March 2018

The Telangana government today proposed a Rs 1,74,453.84 crore budget for 2018-19 with major focus on agriculture as it unveiled a Rs 8,000 per acre investment support scheme and a Rs 5 lakh insurance cover for farmers. Irrigation and welfare are the other thrust areas of the budget.

"The estimated total expenditure in 2018-19 is Rs 1,74,453.84 crore. Of this, revenue expenditure is Rs 1,25,454.70 crore and capital expenditure is Rs 33,369.10 crore," state Finance Minister E Rajender said in his budget speech.

The state revenue is expected to touch Rs 73,751 crore in the current financial year, he said. Agriculture got substantial allocations in the budget.

The budget proposed an amount of Rs 12,000 crore for the Investment Support Scheme to help farmers. An investment support of Rs 4,000 per acre per crop for two crops would be provided to farmers from 2018-19 onwards under the scheme.

The minister said farmers would be covered with a life insurance cover of Rs 5 lakh under a new Farmer Group Insurance Scheme. An amount of Rs 500 crore is proposed in the budget for the scheme.

The budget allocated Rs 522 crore for promotion of farm mechanisation, Rs 127 crore for promotion of micro-irrigation, Rs 120 crore towards polyhouse and greenhouse cultivation. An amount of Rs 15,788 crore has been proposed for agriculture and marketing sectors.

In a reflection of the priority given to irrigation in the budget, an amount of Rs 25,000 crore has been allocated to the sector. Welfare of various sections, including SCs, STs, backward classes, senior citizens has also got major allocations in the budget.

The government is spending Rs 5,300 crore per year on social security pensions to the aged, widows, toddy tappers, and weavers, among others (41,78,291 persons). The budget proposed an amount of Rs 1,450 crore towards 'Kalyana Lakshmi' and 'Shaadi Mubarak' schemes (financial assistance to women for marriage).

The government allocated Rs 16,453 crore to SC Special Development Fund (SDF) and Rs 9,693 crore to ST SDF in 2018-19. For the Scheduled Caste Development department, an amount of Rs 12,709 crore has been proposed. For Tribal Welfare department, an amount of Rs 8,063 crore has been proposed in the budget.

For welfare of backward classes, Rs 5,920 crore has been provided and Rs 2,000 crore proposed for welfare of minorities. An amount of Rs 7,375 crore has been allocated to the medical and health sector.

For construction of double bedroom houses for poor, a major election promise of the ruling TRS, Rs 2,643 crore has been allocated. Funds to the scheme are also provided through off-budget borrowings. The budget proposed Rs 15,563 crore for Panchayati Raj and Rural Development department and Rs 5,575 crore for Roads and Buildings.

Municipal Administration got Rs 7,251 crore and power sector has been given Rs 5,650 crore while Rs 10,830 crore has been allocated for School Education. During the current year 2017-18, the economy of Telangana is estimated to grow at 10.4 per cent in real terms as compared with the national GDP growth of 6.6 per cent, the Finance Minister said.

Growth in manufacturing and agriculture sectors is promising, he said. Advance estimates put the growth of manufacturing sector at 7.6 per cent in 2017-18. The growth of agriculture and allied sectors is estimated to reach 6.9 per cent in 2017-18, the minister said.

"Overall, GSDP at current prices which was Rs 6,41,985 crore last year (2016-17) is estimated to increase to Rs 7,32,657 crore in 2017-18, recording a growth of 14.1 per cent," he said. The per capita income of the state at current prices is estimated to increase by 13.4 per cent to Rs 1,75,534 in 2017-18 from Rs 1,54,734 in 2016-17.

"This is significantly higher than the national growth of 8.6 per cent," he said. As per the Revised Estimates, the total expenditure in 2017-18 is estimated at Rs 1,42,506 crore. Of this, revenue expenditure is Rs 1,06,603 crore, while capital expenditure is Rs 25,447 crore, he said.Lauding the budget, Chief Minister K Chandrasekhar Rao said it is very balanced in making allocations to various sectors.

Source

Back

Is Narendra Modi's crop insurance scheme running aground? – Mint – 14th March 2018

Despite the centre pumping more funds into its flagship crop insurance scheme, coverage among farmers is on the decline, according to figures released on Tuesday, indicating a decline in interest among farmers.

The number of farmers (or farm holdings) covered under the prime minister's crop insurance scheme fell to 47.9 million in 2017-18, from a high of 57.5 million the year before, a sharp decline of 17% in just a year, the government informed the Lok Sabha on Tuesday. The data further shows that while coverage among loanee farmers fell to 35 million in 2017-18 from 44 million the year before, coverage of non-loanee farmers fell marginally from 14 million to 13 million during this period.

In 2016 and 2017, overall, the south-west monsoon which irrigates over half of India's crop area was near normal, meaning rainfall had little role to play in determining insurance uptake by farmers.

While the total number of holdings declined sharply over the past year, gross premium collected by insurance companies in 2017-18 is estimated at Rs24,352 crore, up 9.8% from Rs22,180 crore the year before, the government told the Rajya Sabha on 9 March.

"It is unlikely that insurance coverage in terms of gross cropped area will improve in 2017-18 over the 30% coverage achieved in 2016-17," said a top official with an insurance company who did not want to be named. "Achieving the government's target of covering 50% of gross cropped area by 2018-19 will be a herculean task," the person quoted above added.

The official said that less than 40% of the premium due from state governments has reached insurance companies and that farmers are suffering due to the delay. Interestingly, the centre is yet to calculate the total claims filed by farmers in the current year ending March (2017-18), indicating long delays in settlement of claims.

"The growth rate in agriculture credit fell sharply in the past few years... and due to rising indebtedness and delays in loan repayment by farmers expecting to benefit from loan waivers, it could be that banks are issuing less fresh loans. This could be bringing down the number of loanee accounts and therefore, the (mandatory) crop insurance enrolment numbers," said Himanshu, associate professor of economics at Jawaharlal Nehru University, Delhi.

Himanshu added that the scheme is also failing to interest non-loanee farmers due to delays in claim settlements.

Studies released by Delhi-based think tank Centre for Science and Environment in July 2017, and another last month by the Indian Council for Research on International Economic Relations, Delhi, showed that the Prime Minister's crop insurance scheme is beset with problems like delays in assessment of crop loss and claim settlement, high actuarial premiums charged by insurance companies, and lack of officers monitoring a scheme which gets as much as a third of the budget of the department of agriculture (Rs13,000 crore budgeted in 2018-19).

Source

Back

Reinsurance

GIC Re to start London operations next month - The Economic Times – 15th March 2018

General Insurance Corporation., GICBSE 1.38 % Re is now a step closer in achieving its aim of increasing the share of international business and making India a regional reinsurance hub, as it starts operations in Lloyd's London office next month.

"'GIC Syndicate 1947' has now received permission to commence operations from April 2018, in accordance with the Lloyd's agreed business plan," the company said. Pembroke, a Liberty Mutual Company which is a specialist provider of Lloyd's managing agency services will manage the 'GIC Syndicate 1947'.

This will help GIC Re increase its share of international reinsurance business, which fall fallen to 25%. The country's listed reinsurance company is looking at achieving domestic and international business in the ratio of 60:40.

The state-owned reinsurance company, received approval to set up a syndicate at Lloyd's of London in December 2017, which is expected to help broaden and diversify its international portfolio. Lloyd's is the pre-

eminent reinsurance market in the world with access to specialty risks. GIC Re is present across business lines including fire, property, marine, motor, engineering, agriculture, aviation, health, liability and credit.

Source

It has developed overseas business through branch offices in London, Dubai and Kuala Lumpur. The company is present in 161 countries. It has a representative office in Moscow, a subsidiary in the UK,-which is a member of Lloyd's of London, and a subsidiary in South Africa.

Back

Insurance Cases

25 years on, agent gets 3 years for duping insurer – The Times of India – 14th March 2018

In a 25-year-old case, one of the oldest pending before a magistrate's court in the city, a 58-year-old insurance agent was recently convicted and sentenced to three years in prison for cheating New India Assurance of Rs 16 lakh in 1990-92.

In the case registered in 1993, police alleged that the accused, Ali Hasan, took the divisional manager's help to misappropriate part of the premium amount collected from several vehicle insurance policy holders. Over the next three decades, the divisional manager and other accused were discharged in the case.

Based on information collected from sources, though, the CBI and the ACB registered a case on December 27, 2012.

Initially, the case was registered under the Prevention of Corruption (PC) Act after cops suspected involvement of insurance company officials too. The charge sheet was submitted before the court in 1996. While the divisional manager was discharged in 1998, two other insurance agents booked in the case were granted similar relief in 2001. With no public servant involved in the case, charges under the PC Act were dropped and, by a 2008 order, the matter came to be tried before the magistrate court. It was tried under Indian Penal Code sections.

Nineteen witnesses deposed during trial. Key witnesses included two internal auditors of the insurance company. The duo told the court that on directions of the chief manager, in 1993, they conducted an audit on the motor insurance policies booked by Hasan. The auditing was done for the period April 1, 1990, to November 11, 1992. The duo told the court they found that Hasan had shown lower premium amount in daily collection sheets than those actually shown on the policy. Further, they submitted that Hasan had fabricated the documents and caused loss of more than Rs 16 lakh to the insurance company.

Relying on witness statements, the court found Hasan guilty on charges of cheating, criminal breach of trust by an agent and falsification of accounts.

While seeking leniency for the Andheri-based accused, the defence submitted that the case had gone on for more than two decades and the accused had attending the court regularly. The defence also said the accused was very poor, had no adequate source of income and his two daughters depended on him. Opposing this, the prosecution submitted that this was an economic offence against the country and such offences have to be dealt with a special approach because of public funds involved. The prosecution further submitted that misappropriation of more than Rs 16 lakh was committed and the value of that amount was very high more than two decades ago.

Source

While the maximum sentence was seven years' imprisonment, the court sentenced Hasan to three years' imprisonment and fined him a total of Rs 45,000.

Back

Kidney patient harassed, insurers pay highest cost – The Times of India – 12th March 2018

The district consumer disputes redressal forum has awarded its highest ever "deterrent compensation" of Rs 1 lakh to an insurance buyer from Zirakpur on his complaint against two companies who had denied him medical claim for the treatment of his wife for kidney disease.

National Insurance Company, Sector 34, and Vipul MedCorp Insurance TPA, Industrial Area Phase II, Chandigarh, were found guilty of manipulating facts and misinterpreting the terms and conditions of a medical policy to reject the medical claim of Zirakpur's Shiv Kumar. The insurers were directed to repay him the

deducted amount of Rs 1.88 lakh along with 12.5% interest from the date of repudiation of claim (February 7, 2017) to the realisation of the payment.

Shiv Kumar had bought Mediclaim insurance policy from the companies for Rs 5 lakh, with a cumulative bonus of Rs 1.35 lakh effective from February 22, 2016, to February 21, 2017. Under this policy renewed in 2006, his wife and two sons were insured. In 2016, his wife was diagnosed with kidney disease, for which she took treatment worth Rs 3.69 lakh from a Mohali hospital. However, the insurers only passed Rs 1.80 lakh to the family and deducted the rest wrongly.

TPA's reason for the deduction was that the complainant's wife had come into this condition because of a preexisting disease (hypertension) and was covered after four years. This is despite the fact that she never had hypertension or took any medication for it, except during pregnancy more than eight years ago.

The companies even reduced the sum insured from Rs 5 lakh to Rs 4 lakh without any plausible reason. The complainant requested them to consider his case for reimbursement of the balance claim, but in vain. National Insurance stated in its reply that if a subscriber had hypertension, her expenses towards hypertensive nephropathy (treatment of kidney disease because of high blood pressure) were not payable.

Shiv's wife, Mamta, has continuously been on dialysis because of kidney failure. Keeping into consideration the harassment to her, the forum observed that it has eroded her faith in the insurance system, as she didn't get the money despite emergency requirement.

Source

Back

Interview

'Remove the complexity from insurance products and free up distribution' – Mint – 12th March 2018

Sandeep Bakhshi, who was due for retirement, has got an extension for 2 years. Bakhshi has headed the company for nearly 8 years now. Under him, in 2016, it became the first life insurance company to go public. In conversation with Deepti Bhaskaran, Bakhshi talked about his unfinished business and how the product committee is set to bring in the next wave of reforms in cleaning up insurance products. Edited excerpts:

You have an extension of 2 years. What's the unfinished business that you would be focussing on?
Simplifying on-boarding is my dream. Life insurance products, which also offer investments, should be as easy as it is to buy a fixed deposit from a bank; and pure life insurance products should be as easy as buying a motor insurance policy. We have to make on-boarding smooth, and with databases like Aadhaar and Cibil that are excellent surrogates, the whole process of underwriting can be quick.

I am confident that I will realise this dream before my term ends. I feel that in the protection category we have barely scratched the surface. It's a myth that people don't buy life insurance if the product doesn't offer returns. Term plans as a category have become hugely popular in the past couple of years and we want to go beyond just the salaried. Documentation is a big roadblock currently because for financial underwriting we need income proof; but with demonetisation, financialisation of assets and the implementation of Goods and Service Tax (GST), it has become so much simpler.

Protection and investment are societal needs and protection comes first in the pecking order. We, as an industry, haven't done much there and I hope that changes.

In term of savings products also, I feel we should do more. Insurance is a long-term product, so we are not in the short-term market where fixed deposits and mutual funds operate, but these same products operate in the long-term market also. Mutual funds have popularised systematic investment plans (SIPs) whereas the Life Insurance Corporation of India (LIC) has captured single premiums.

Private sector has ignored both. So from FY2015 to September 2017, mutual funds grew from around Rs10 trillion to about Rs22 trillion, LIC grew from about Rs17 trillion to around Rs22 trillion, whereas the private sector grew from around Rs4.8 trillion to just about Rs6.3 trillion. Clearly we missed out on the opportunity. I feel product simplification and freeing up distribution will help us grow.

One of the things that can make insurance misselling proof is to offer customers easy exit options. However, while traditional products charge the entire premium as penalty if you exit in initial years, the surrender costs are very low in unit-linked insurance plans (Ulips). Why this different treatment?
There is a notion that traditional investment products are protection products whereas Ulips are investment plans—but this is wrong. It's important to understand that products such as term plans are protection plans whereas the traditional money-back, endowment, guaranteed plans and even Ulips are investment products. All these investment plans offer a minimum of 10 times the annual premium as insurance cover, they invest in debt and equity and offer the choice between single and regular premium options. There's no difference between the two products except when it comes to surrender costs and there is no reason why traditional plans can't adopt the exit charge structure of a Ulip.

The product committee report recognises high surrender costs to be a problem but also states that most in the industry want status quo. What do you think?
At the end of the day, construct of insurance products has to be from a customer's lens. It has to offer value and fairness to customers. Our inability can't be the base for not offering something that's fair. If the need is protection or if the issue is a possible loss to a customer if the policy doesn't complete the premium payment term, we need to look at products that address these needs and issues.

But why is the industry still so hesitant? What sort of regulatory changes need to happen?
Insurance industry comprises life insurance and general insurance. Most of the complaints in general insurance are around claims settlement. And many times it's the fine print in exclusions that result in rejection. So when the system looks at what the main issue is, then over a period regulations begin to address it. In life insurance if you see a large part of complaints are around not understanding the products, and if you see how regulation panned out, it addressed these issues in Ulips. This is bound to happen with traditional plans also. The fact that committee reports show an arbitrage in surrender costs between Ulips and traditional plans, it is recognition that there is a problem and I am sure regulations will address it.

But you should understand that traditional savings plans have been the bedrock of the industry and making fundamental changes to them will not be easy. Plus, this comes at a time when the industry is finally seeing growth and improving some important parameters such as persistency. So, should we disrupt this momentum or give the industry more time to demonstrate its ability? I think there is no doubt about reforms but it's the pace that needs to be thought through.

Interests of industry and the customers are aligned. Protection products offer maximum profit margins and persistency is key for long-term health of a company. The same things are good for customers as well. But historically, this is not how insurance was sold. Is it because the industry is hostage to distribution, which focuses more on commissions? Is there a need to re-look commissions as well?
Insurance will always depend on distribution and I think most other financial products depend on it, so that's not going to change. But... historically there was a huge disconnect between the insurer and the customer. It was agents who owned the customers and insurers interacted with agents. But that's changed dramatically as insurers are beginning to own their customers. Today the concept of orphan policies doesn't exist because even when an agent leaves the company, the direct team of the company takes over. Historically the customer was one step removed from the insurance company but now that's not the case. I think it's the ability of insurers to reach out to customers directly that has transformed the whole architecture.

Talking about commissions, I think we are getting bogged down too much by commissions. In my opinion controlling commissions is not the solution but making insurance misselling proof is. One needs to make sure that there aren't any issues in the product that the customer can be confronted with. After that, how much I pay to the distributor should be my decision. This, of course, will be within the overall cap of expenses of management that's already defined.

Thus, it's the product that needs to evolve and I feel commissions should be freed up because each distribution architecture has different cost pressures and we need to compensate it accordingly. We also need to focus on flexibility of distributors. A distributor should be able to sell a gamut of life, health, motor insurance, mutual funds and loans. This is how the distributor is going to own the customer. The solution is to remove the complexity from products and free up the distribution.

Source

Pensions

India: Membership of National Pension Scheme to reach 21 mln at 31 Mar - Asia Insurance Review

The Pension Fund Regulatory and Development Authority of India (PFRDA) is expecting the number of National Pension Scheme (NPS) subscribers to hit 21 million by the end of this financial year which falls on 31 March.

Mr Hemant Contractor, PFRDA Chairman, said that they currently have 20.5 million subscribers, reports Moneycontrol.

"We had a good response from corporate subscribers as well for NPS. The number of corporate subscribers has gone up to 4,400 and this year itself 935 corporates have signed," said Mr Contractor. He added that there is a higher demand for e-NPS, which is a digital version of the scheme.

Established in 2004, NPS is a voluntary, defined-contribution retirement savings scheme designed to enable subscribers to sav for their retirement.

Under the NPS, individual savings are pooled in to a pension fund, which is then invested by PFRDA regulated professional fund managers as per approved investment guidelines in government bonds, bills, corporate debentures and shares.

At the time of a normal exit from NPS, subscribers can use the accumulated pension wealth under the scheme to purchase a life annuity from a PFRDA-empanelled life insurance company, apart from withdrawing a part of the accumulated pension wealth as lump sum, if they choose to do so.

Earlier this month, the PFRDA relaxed the rules to allow partial withdrawal under the NPS. The subscriber must have subscribed to the NPS for at least a period of three years to be eligible to make partial withdrawals. The subscriber can withdraw a maximum of three times during the entire tenure of his subscription under the NPS. The partial withdrawal is linked with the contributions made by the subscriber who shall be permitted to withdraw accumulations not exceeding 25% of the contributions made by him or her and standing to his or her credit in his or her individual pension account, as on the date of application for withdrawal.

Source

Back

Global News

Taiwan: Insurance sector produces spectacular premium volume in 2017 - Asia Insurance Review

The Taiwanese insurance industry performed brilliantly last year, with total premium income of NT$3,576.9 billion (US$122.8 billion), a record high, according to Mr Hsien-Nung Kuei, Chairman of the Taiwan Insurance Institute (TII).

The figure exceeds a forecast last year that the insurance sector would see total premiums of NT$3,000 billion for the year. The NT$3,576.9-billion actual premiums represent an increase of 9.1% over 2016.

Source

Of the total last year, life premiums amounted to NT$3,420 billion representing an increase of 9.2% over 2016, while non-life premiums grew by 7.4% to reach NT$156.7 billion.

Back

Singapore: Motor sees first underwriting loss since 2010 - Asia Insurance Review

Motor insurers in Singapore are expected to review the commercial viability of their business after booking a combined underwriting loss of S$27.2 million (US$20.8 mln) in 2017 compared to the previous year - the segment's first underwriting deficit since 2010.

The general insurance industry's 2017 full year results announced by the General Insurance Association of Singapore (GIA) yesterday, revealed a 3.3% drop in gross motor premiums to S$1.1 billion while claims rose by 12% representing an increase of S$60 million.

"The industry will invariably have to look at the cost and revenue part of it and companies will have to make their own decisions, but there's so many players in the market so I think it will take some time before we see the effect of this," said GIA President, A K Cher, in response to the question of whether insurers will raise motor premiums.

Singapore's average motor premium eased by 3.9% to S$1,155 in 2017, resulting from increased competition in the largely saturated motor insurance market.

Loss ratios in motor saw an 11 point jump to 64.9%, the highest recorded by the industry in the last five years.

Meanwhile, the number of reported accidents have been on the rise for the last two years with 167,549 cases reported in 2017, compared to 162,838 and 149,511 in 2016 and 2015 respectively.

While more detailed analysis is required, Mr Cher suspects the use of mobile phones on the roads and the increase in rental/private hire fleets could be the main contributors to an increase in road accidents over the past two years.

Motor remains the largest segment for general insurance in 2017 at over 30%, followed by health at 13.6%.

Rising healthcare cost

Health premiums amongst general insurers in Singapore - largely focused on group term policies - saw a marginal decline of 0.7% in 2017 to S$500 million. The segment posted an underwriting loss of $S28 million, continuing the downtrend seen in 2016 where losses stood at S$18.7 million.

The rapid pace of medical inflation remains the biggest factor influencing this segment and the GIA will closely align its efforts with that of the Life Insurance Association of Singapore to manage rising medical inflation in Singapore.

Mixed performance

Reflective of the competitive market conditions in the general insurance sector, overall underwriting profit for the industry contracted to S$107 million, while gross premiums rose by 0.8% to S$3.68 billion.

And while the motor and health segments recorded declines, fire, personal accident, marine cargo and hull were among those that registered increases in gross premiums in 2017.

While the challenging market conditions are expected to persist this year, the general insurance industry intends to stay focused on the core areas of improving automation and embracing digital solutions to forge a stronger sector.

Source

There may also be some prospect of consolidation in the sector where 36 general insurers currently operate, with participants acknowledging that it is overcrowded.

Back

China: Insurance and banking regulators to merge – Asia Insurance Review

China will set up a banking and insurance regulatory commission, according to a plan submitted yesterday to the national legislature, the National People's Congress (NPC), that would be a major revamp for the financial sector aimed at curbing risk.

The new commission is mainly responsible for supervising the banking and insurance industries, preventing and dissolving financial risks and protecting consumers' rights.

The CIRC and the China Banking Regulatory Commission (CBRC) will be dismantled, as a part of institutional restructuring of the State Council.

The Communist Party which controls the government has stated that its priorities this year include reducing financial risk following a run-up in corporate and local government borrowing that prompted global rating agencies to cut Beijing's government credit rating last year.

The new regulator will be capable of "holding the bottom line to prevent systematic financial risk", the NPC document says.

The responsibilities of the two separate regulators currently overlap in some areas, leaving regulatory roles unclear, the document says.

The merger of the two regulators is seen as a move which would give the government a better handle on supervising the insurance and banking sectors which have seen increasing cross-sectoral transactions that hide levels of lending and risk. The two regulators will hand off duties such as proposing laws to the People's Bank of China in a sign that the central bank is stepping up its regulatory role.

Other signs of the growing power of the central bank include the PBOC's adoption of a so-called Macro Prudential Assessment framework, to better gauge risks in the entire financial system as well as the health of individual institutions. Off-balance sheet wealth management products and other shadow banking activities were later included in the framework, reports Bloomberg. The proposed changes set out in the NPC document are expected to be approved by lawmakers who end their annual session next Tuesday.

Source

Back

Asia: Trust and competence are necessary for brokers to survive – Asia Insurance Review

In a time where brokers and insurers alike are looking towards technology to find solutions to their pain points and to remain competitive in the market, Mr Jeremy Lee Eng Huat, Director of Consumer and Market Conduct Department at Bank Negara Malaysia said that the human touch can never be replaced. During his keynote address yesterday morning at the 6th Asia Insurance Brokers Summit, held in Kuala Lumpur, Malaysia, Mr Lee said: "Trust is not only necessary but is also the defining value proposition of the entire broking profession. The key differentiator between a good and a great insurance broker is their ability to establish long-term valuable relationships between yourselves, the insurers and their clients."

He reminded the crowd of 130-odd brokers, insurers and reinsurers that in the financial services sector, insurance is still not as much of a norm as banking, and that brokers are critical to closing the gap in the sector and narrowing the asymmetry of information between insurers and their clients.

Accomplishing this difficult task requires the clever use of existing and future technologies. Mr Marcellus Wong, Vice Chairman of the Board of Directors of AMTD Group, said: "The key for an insurance broker to outperform its peers is to embrace the benefits of technology, recognise areas of opportunities and establish expertise, with differentiated services. However, this requires management's commitment to a top-down and bottom-up change to create an innovative culture and balance short-term profit and long-term viability."

He saw that the inevitable trend is for the corporate insurance brokerage industry to keep consolidating, and that players with global ambitions will look to expand their international network, in order to provide global risk solutions, achieve geographical diversification and economies of scale. "At the same time, we also consider that the small and local independent brokers will always exist. These smaller players could potentially serve small and medium-sized enterprises well and tap into new market segments and related client education. Currently in Asia, most SMEs don't get insurance at all or only have very primitive coverage," he said.

Mr Robert Kelly, MD and CEO of Steadfast Group Limited, Australia, said that what will reshape broking is what the insurers are doing, likening the relationship between brokers, insurers and their clients as a mutually beneficial marriage and partnership of equals. "Insurers are moving quickly on upgrading their systems, business models, their data collection and analysis, and how they handle clients in the digital world," he said. He added that technologies such as artificial intelligence and algorithms will not redefine insurance, but simply analyse and dictate the risk appetites of insurers, which is what brokers need to tap into for continued success in the industry.

Source

The summit is organised by Asia Insurance Review and co-organised by AMTD Group and Steadfast Group.

Back

China: January 2018 total premiums fell by 20% on plunge in life sales - Asia Insurance Review

China's insurance industry premium income fell by 19.9% to CNY685 billion (US$109 billion) in January, according to data from the country's insurance regulator, according to data from the CIRC. The decline in life premiums in January 2018 is attributed to the CIRC's crackdown last year on risky short-term universal life insurance products.

Total assets of the insurance industry stood at CNY16.9 trillion at the end of January, representing an increase of 0.93% from the beginning of the year. January 2017's life premiums contributed 32% of the total life premiums of CNY2,675 billion for the whole of last year.

Source

Singapore: Life sector signals 2018 as a busy year with slew of goals - Asia Insurance Review

Life insurers will focus their efforts this year on enhancing protection for the public and improving industry standards, according to Mr Mr Patrick Teow, the President of the Life Insurance Association Singapore (LIA Singapore).

He said that the life industry's three priorities are:

- Spearheading initiatives to help individuals get adequately insured with the release of the Protection Gap Study in late March which will shed light on mortality and Critical Illness protection gaps in Singapore,
- Ensuring healthcare accessibility with ongoing efforts by the Health Insurance Task Force (HITF) and key stakeholders including the Ministry of Health (MOH) to act on recommendations put forth by the independent HITF – initiatives including but not exclusive to product redesign of plans to control unnecessary consumption of healthcare, and
- Close collaboration between MAS and the industry on guidelines for the recruitment and migration of financial adviser representatives. MAS will conduct a public consultation on this at a later date.

Mr Teow was speaking at the annual luncheon last week of LIA Singapore, at which the guest of honour was Mr Ong Chong Tee, Deputy Managing Director for Financial Supervision, Monetary Authority of Singapore (MAS).

Mr Ong highlighted the importance for life insurers to ride the technology wave to bridge the protection gap, and to ensure good market conduct.

He said: "This brings me to the potential for FinTech, or more specifically InsurTech, to help reduce the protection gap. Technology solutions offer exciting possibilities to alleviate many pain-points associated with the understanding, buying and servicing of life insurance products.

"To be sure, the insurance sector has always employed technology tools and is a large user of data. This is also part of the problem.

A recent McKinsey report stated that 90% of insurers identified complex legacy systems as the key barrier to digitisation. It is only in the more recent one to two years that InsurTech has been recognised as a change driver."

Conduct gaps

Referring to conduct gaps, Mr Ong said: "Recent episodes of large-scale movement of representatives have cast the industry in an unfavourable light.

Such mass recruitment of representatives by one firm gives rise to heightened market conduct risks, with respect to aggressive sales tactics and improper switching.

"MAS has worked closely with LIA on measures to address these risks and we will be issuing a public consultation soon to promote responsible recruitment practices in the financial advisory industry."

Meanwhile, LIA members have agreed that they, as well as their Financial Advisory (FA) subsidiaries will go ahead to adopt a number of these measures which include:

(a) Capping a representative's sales targets and sign-on incentives in the first year after the representative joins the new FA firm. This reduces the pressure on representatives to engage in aggressive sales tactics to meet inflated sales targets;

(b) Spreading sign-on incentives over a minimum period of six years, to create longer- term alignment between the representative and his new FA firm. This will foster better quality after-sales services to customers;

(c) Reducing the entitlement to sign-on incentives if the persistency of the policies serviced by the representative at his previous firm falls below industry norms, to deter improper switching; and Requiring the FA firm to undertake enhanced monitoring of its representative's sales transactions to verify that the sales and advisory process has been properly conducted, which will include customer call-backs conducted by an independent external party.

Source

The annual luncheon was preceded by elections of office bearers of the association that took place during the Annual General Meeting held on the same day. Mr Teow and Mr Ken Ng were re-elected President and Deputy President for 2018-19, extending their tenure for the second and fifth consecutive year respectively. They are joined by Mr James Tan who began his first term as Deputy President.