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QUOTE OF THE WEEK

"The best preparation for tomorrow is doing your best today."

H. Jackson Brown, Jr.

INSIDE THE ISSUE

INSURANCE INDUSTRY

Insurance industry goes on tech drive to expand coverage - Financial Chronicle – 31st December 2018

Technology is the new friend in town for insurance industry as it strives to add more customers in a country that still remains largely under-insured, after a year full of reforms and introduction of easier-to-understand products. The list of reforms undertaken in 2018 is long — diseases such as HIV and mental illness were brought under policy covers, long-term third-party motor insurance became mandatory and the government launched its ambitious scheme Ayushman Bharat that seeks to cover almost 50 crore people.

It was also a year of digitisation and launch of customer-friendly products as there was a rapid growth in online channel, Canara HSBC Oriental Bank of Commerce Life Insurance's MD and CEO Anuj Mathur said. The sectoral regulator Insurance Regulatory and Development Authority of India (Irdai) proposed to encourage companies to develop new technologies, asked insurers to make their products more attractive and customer friendly.

"With increased use of digital mode… there was increased focus on point of sale products and simple to use channels to increase penetration of life insurance products in sub-urban and rural areas," Mathur said. Government's massive health insurance scheme Ayushman Bharat will go a long way to bring the poorer segment of the society under policy cover, he said. Mathur expects health insurance sector to see more innovative and customised products in coming years due to efforts of the Irdai. HDFC Life's Executive Director Suresh Badami said private sector has continued to gain market share in last three years and industry should continue to see growth momentum as the regulator is taking very positive steps towards increased transparency and benefits to customers.

"Insurers will introduce simpler products which will provide customers with the maximum value for their hard-earned money. The exposure draft on the new product regulations has been circulated with the member companies… The insurance industry at large has shared its comments with the regulator and hopefully, the recommendations would be incorporated in the notified regulations," he said.

However, he said, the protection gap is a serious concern that is being addressed through various financial protection products designed for the changing lifestyles of Indian consumers. According to a survey, life insurance penetration in India is less than 3 per cent as compared to other developing nations.

"Insurers are making continuous efforts to address the challenge. The government has been taking concrete steps towards this direction as well," Badami said. The private life insurance industry witnessed a 20 per cent compounded annual growth rate (CAGR) during the year. "I expect the industry to continue to leverage the benefits from several initiatives it started in 2018. We will see companies invest more in product innovations using the sandboxing platform, to offer more value-packed products for customers," said Bajaj Allianz Life MD and CEO Tarun Chugh said. There will be robust adoption of technology-backed servicing initiatives for customers, sales force and agents alike.

With the opening up of payment banks, small finance banks and other similar partnerships, life insurance products will reach many more Indians and help them secure their and their family's future, he said. Ashish Mehrotra, MD & CEO at Max Bupa Health Insurance said some key trends to be watched in 2019 will be greater technology integration in health insurance products, with wearable playing a significant role.

Integration of wearables in health insurance products will allow insurers to curate tailor-made products as per a person's current health records, thereby curbing the need for pre-policy checkups and charging premiums more appropriately as per an individual. During the year, health insurance policies were made more comprehensive and easy to understand for consumers. The industry hopes that the reform measures taken by Irdai may come into action within the next 12 months. The double-digit growth of the

Indian insurance industry was aided by enhanced penetration, increasingly informed and aware customers, efficient distribution channels and government schemes, global insurance brokerage firm Willis Towers Watson's India Head Rohit Jain said.

The regulatory and legislative dynamism across the spectrum of life, non-life and health insurance is paving way for newer possibilities. There is a continuous blurring of line between the digital and physical space, indicating the tectonic shift the industry will be witnessing in the coming years, Jain said. "With a healthy capital flow, the insurance markets continued to price the risk softly and generated a bit of consolidation activities too," he added. Bajaj Allianz General Insurance MD & CEO Tapan Singhel said 2018 was also a year of consolidation as many regulations were introduced by Irdai on motor insurance, health insurance, crop insurance which were focused on customer centricity and simplification of products and processes for them.

TOP

Source

PE funds seek to enter insurance from Mauritius – The Economic Times – 31st December 2018

With large private equity investors eyeing the insurance sector, the insurance regulator has received requests to allow PE funds to invest from Mauritius. At present, the regulator has allowed private equity firms to invest in insurance companies as a financial investor directly or as a strategic investor by floating a special purpose vehicle and registering it with the Securities & Exchange Board of India.

The regulator has put a lock-in period of five years for PE funds in insurance. This year, large PE funds such as West Bridge Capital, Warburg Pincus and True North have invested in the sector.

"Private equity funds want to come through Mauritius," said a source close to the development. "In the present form, if they become promoter, they have to register with Sebi."

The regulator wants strategic investors to enter the insurance sector and that's the reason they had put a lock-in of five years. It allowed private equity funds to invest either directly in Indian insurance companies in the capacity of an investor, or invest through a special purpose vehicle in the capacity of a promoter in the insurance company. If a PE wants to buy more than 10 per cent, it has to float an SPV to invest in an insurance company. For an SPV, the fund needs approval from the department of economic affairs at the ministry of finance.

"Irda wants the entity to be responsible," said the CEO of an insurance company. "It has asked the funds to register with the capital market regulator to know the jurisdiction. Irda cannot check the origin and investors of the fund if it is coming from Mauritius and Bermuda."

The greater interest of PE funds in the Indian insurance space is triggered by three reasons — growth of insurance market which demands utilisation of a lot of capital, extensive use of technology blurring the line between insurance and technology companies, and emergence of financial investor in an industry which now shows profitability, said Joydeep Roy, partner at PwC. "The PE fund's choice would be to invest from their favoured location where the funds reside for the sake of simplicity," said Roy. "However, the regulator may find it challenging to accept that."

Irda had issued guidelines in December 2017 to facilitate and regulate investment by private equity funds in insurance companies as investors and promoters.

West Bridge along with Rakesh Jhunjhunwala's Rare Enterprises and Madison India had invested around Rs 6,500 crore in Star Health Insurance, Warburg Pincus in ICICI Lombard and Indiafirst Life Insurance. Talks are on about True North investing in Max Bupa. The number of deals is on the rise as existing promoters are looking to exit or monetise their investment after a decade.

TOP

Source

HEALTH INSURANCE

Disabled must get insurance benefit even when parents are alive: SC - The Economic Times – 4th January 2018

The Supreme Court on Thursday said that insurance policy taken by parents or guardians for disabled child should be allowed to mature after 55 years of age of proposer against the present practice of giving lump sum payment to disabled dependent only in the event of death of the guardian.

A bench of Justices A K Sikri, Ashok Bhushan and Abdul Nazeer said that there could be "harsh cases" where handicapped persons may need the payment on annuity or lump sum basis even during the lifetime of their parents/guardians and asked the Centre to examine the issue.

The court also asked the legislature to consider amendments in Section 80DD of Income Tax Act where the exemption is given only to those investment made by a guardian for insurance policy which provides payment to disabled person only after the death of the proposer. The court said that judiciary cannot take upon itself the task to amend the law and it is for the Parliament to examine it.

"For example, where guardian has become very old but is still alive, though he is not able to earn any longer or he may be a person who was in service and has retired from the said service and is not having any source of income. In such cases, it may be difficult for such a parent/guardian to take care of the medical needs of his/her disabled child. Even when he/she has paid full premium, the handicapped person is not able to receive any annuity only because the parent/guardian of such handicapped person is still alive. There may be many other such situations. However, it is for the Legislature to take care of these aspects and to provide suitable provision by making necessary amendments in Section 80DD of the Act," the court said.

The court passed the order on a plea filed by a differently abled person Ravi Agrawal seeking its direction to Centre and Life Insurance Policy to allow the beneficiary of insurance of policy to withdraw amount during the lifetime of parents who have taken Jeevan Aadhar Policy from LIC for the livelihood of their children. Even the Chief Commissioner for Persons with Disabilities also came in support of the petitioner and had said that like other police holders, Jeevan Aadhar policy should also be allowed to mature after 55 years of age of the proposer and the annuity amount should be disbursed.

"In the aforesaid circumstances, we dispose of this writ petition by urging upon respondent No.1 (Centre) to have a relook into this provision by taking into consideration all the aspects, including those highlighted by the Court in this judgment, and explore the possibility of making suitable amendments," the court said.

TOP

Source

Government decides to replace healthcare body, forms National Health Authority – The Economic Times – 2nd January 2018

The government Wednesday decided to dissolve the National Health Agency and approved formation of a new body named National Health Authority for better implementation of Ayushman Bharat, the Centre's healthcare scheme for the poor.

The existing society -- National Health Agency -- has been dissolved and will be replaced by the National Health Authority as an attached office to the Ministry of Health, an official statement said.

"The existing multi-tier decision making structure has been replaced with the Governing Board chaired by the Union Minister of Health which will enable the decision making at a faster pace, required for smooth implementation of the scheme," the statement said.

Welcoming the Union Cabinet's decision, Health Minister JP Nadda said, "The world's largest healthcare scheme rightfully deserves the most efficient and effective governance structure with total accountability."

The composition of the Governing Board of the new body is broad-based with due representations from the government and domain experts. Besides, the states shall also be represented on the Board on rotational basis.

"No new funds have been approved. Existing budget that was approved earlier by the Cabinet for The National Health Agency, including costs related to IT, human resources, infrastructure and operational costs would be utilized by the proposed National Health Authority," the statement stated. It is envisaged that the National Health Authority shall have full accountability, authority and mandate to implement the scheme through an efficient, effective and transparent decision-making process, it said.

TOP

Source

PMJAY Ayushman Bharat: Nearly 7 lakh provided treatment in first 100 days – Financial Express – 2nd January 2019

Over 6.95 lakh beneficiaries have availed free hospitalisation benefits worth Rs 924 crore in the first 100 days of the Pradhan Mantri Jan ArogyaYojana (PMJAY), which offers Rs 5-lakh-a-year free health cover to 10.7 crore households. “Once awareness on the scheme increases, it is anticipated that in the next few years, almost 1 crore plus families will benefit each year,” finance minister Arun Jaitley said in a Facebook post, lauding the scheme as a game changer in healthcare.

In the first 100 days, 5.29 lakh hospitalisation claims have been filed worth about Rs 684.6 crore, with average hospitalisation cost of`12,932 per patient. NITI Aayog had estimated average cost to be about Rs 10,000 as the scheme matures. PMJAY was rolled out on September 23. State governments and the National Health Agency (NHA) have empanelled over 16,000 hospitals under the scheme, more than half of which are from private sector. Efforts are on to empanel more branded specialty hospitals under the scheme.

NHA plans to issue about five crore beneficiary cards to inform people and generate hospitalisation demand from rural population. The hospitalisation and treatment cost are shared in 6:4 ratios between the Centre and states. The cost of the scheme would be much lower in FY19 as half of the year is over.

For 2018-19, the PMJAY might cost the Centre about Rs 4,000 crore (including one-time investments on IT) and the states about `1,600 crore. The scheme might provide hospitalisation benefits to 25 lakh in the current fiscal year. So far, bulk of the beneficiaries is from Gujarat, Tamil Nadu, Chhattisgarh, Karnataka and Maharashtra, the states which had prior experience of similar schemes. Most of the states are also implementing the scheme under trust model.

TOP

Source

Ayushman Bharat a ‘game changer’ in healthcare: Jaitley - The Hindu Business Line – 1st January 2019

Up to 6.85 lakh patients have been provided treatment in the first 100 days since launch of Pradhan Mantri Jan ArogyaYojana (PM-JAY) popularly referred to as Ayushman Bharat, Union Finance Minister Arun Jaitley said in a statement today.

Also, 5.1 lakh claims have availed of the scheme, for which payment has been released. “This averages 5000 claims per day for the first 100 days. No patient has had to pay a single Rupee,” stated Jaitley.

The total number of hospitals covered by this scheme is both Government hospitals and private hospitals presently numbering 16,000 and increasing steadily. “More than 50 per cent of the implementing hospitals are in the private sector. Thus, a patient can enroll himself in empanelled hospital and get

himself hospitalised upto charges of Rs. 5 lakh in a totally cashless and paperless manner," he emphasized.

Launch of the scheme and its implementation has been relatively problem free, he observed. He further stated that 62.58 per cent of the Indian population has to pay their healthcare bills themselves. "Most find it unaffordable. Low healthcare insurance penetration, low financial protection and high out of pocket expenses pose major challenges," he says.

Explaining the reasons behind it, Jaitley stated, "India's healthcare system was always lacking. Besides inadequacy of healthcare institutions proportionate to India's population, there were many other challenges. Besides important State supported institutions, the private institutions have now been established mainly around large metropolitan towns or Tier-I or Tier-II cities. Many public and private hospitals are of global quality. Their charges, if we compare to the cost elsewhere in the world, are extremely competitive, but for a large part of India's population, these are considered beyond reach."

The Government employees and those in other public institutions are generally supported by governmental healthcare programmes. Those in the armed forces are supported by the healthcare provided in those institutions. Some private sector corporates have a healthcare provision as part of their service conditions, but still a majority of population is deprived.

"Once awareness of the scheme increases, It is anticipated that in the next few years, almost 1 crore plus families will benefit each year," Jaitley stated.

TOP

Source

Ayushman Bharat: 10,000 beneficiaries hospitalised per day in December - The Economic Times – 30th December 2018

Number of hospitalisations under Ayushman Bharat has more than doubled in the last three months with tertiary care procedures such as angioplasty, joint and valve replacement as well as cancer care accounting for 77% of the Rs 897 crore pre-authorised for hospitalisation under the government's flagship health insurance scheme so far, latest data from National Health Agency shows.

The average number of beneficiaries admitted to hospitals increased to 10,000 per day in December from around 2,000-5,000 in October. The compounded monthly growth in number of hospital admissions under the scheme is estimated at 47% since October, according to the available data. A total of 6.73 lakh patients have sought hospitalisation under the scheme so far since its launch on September 23.

States like UP, Bihar and Jharkhand, where health indicators have been poor, show a significant jump in number of hospitalisations. UP recorded 70% increase in hospital admissions under the scheme in the last one month, Jharkhand recorded over 67%, whereas it rose by more than 50% in Bihar.

This assumes significance because tertiary or critical care is exorbitantly priced in private hospitals and therefore has been mostly out of the reach of the poor so far. While the number of secondary procedures like dental surgeries and general medicines continue to be higher, tertiary care cases have also increased significantly in the last one month, officials say.

"The change in trend is mainly triggered by awareness about the scheme. More than 7.5 crore letters from PM have been distributed to beneficiaries through ASHA and postal department. This has effectively reached around 30 crore beneficiaries. As people are getting aware, the scheme is making them empowered," says Dinesh Arora, deputy chief executive of Ayushman Bharat.

The jump in hospitalisation, mainly in tertiary care, is also prompted by the increase in empanelments of hospitals in the last couple of months, Arora said. As per data, 65% of the beneficiaries received treatment in private hospitals, reflecting a rise in accessibility of critical care.

TOP

Source

Govt finally terminates health insurance policy - The Tribune – 28th December 2018

Putting all speculations to end, the state government on Friday finally issued a notification for revocation of the controversial J&K Group Mediclaim Insurance Policy for all state government employees with effect from December 31 midnight.

An order of the state finance department said the sanction was accorded to the revocation or withdrawal of the government order issued on September 20 regarding the implementation of the insurance policy for all state government employees, including employees of public sector undertakings (PSUs), autonomous bodies, universities and pensioners with effect from December 31 midnight.

Accordingly, all drawing and disbursing officers (DDOs) have been directed not to deduct the premium from the salaries of employees henceforth.

On September 20, the state finance department had notified the implementation of the policy for about 4.5 lakh government employees, including 1.6 lakh pensioners and their dependent family members. The policy had been tied up with M/s Reliance General Insurance Company Ltd. The policy promised health insurance coverage up to Rs 6 lakh per employee or pensioner per annum along with their five dependent family members on a floater basis. The annual premium for the insurance cover was to be deducted in four quarterly instalments.

However, Governor Satya Pal Malik on October 24 had announced the cancellation of the policy after the detection of multiple frauds and ordered a high-level probe into the matter. He had disclosed that the government officers did not call tenders for the policy and a front company had been floated by some officers to call the tenders. "The tender were opened on a holiday to suit a company. A fraud was established in the implementation of the scheme that led to cancellation of the agreement with the insurance company," Malik had said. — TNS

TOP

Source

CROP INSURANCE

Coalition government plans own crop insurance scheme – The Times of India – 2nd January 2019

The JD(S)-Congress government has proposed to roll out its own crop insurance scheme because it sees the Centre's Pradhan Mantri Fasal Bima Yojana (PMFBY) as a failure. The government is mulling launching a state-run insurance company to effectively implement the scheme and help needy farmers.

"Besides PMFBY's systemic loopholes, private companies are taking advantage of it and making money at the cost of farmers," agriculture minister HN Shivashankar Reddy said, adding: "This necessitates the launch of a state-run insurance company." Stating that the proposal is in a preliminary stage, the minister said he has convened a meeting of officials and domain experts on Thursday to deliberate on the proposed insurance company and modalities of the plan's implementation.

Reddy said he's also planning to send a delegation to Bihar to study its insurance scheme, which was launched in May last year after realising that PMFBY is of little help to farmers. The number of farmers benefiting from PMFBY has been plummeting over the years. About 5.7 crore farmers got their insurance claims cleared in 2016-17 and the number reduced to 4.9 crore in 2017-18.

Kiran Kumar Vissa, national coordinator of Alliance for Sustainable & Holistic Agriculture, said farmers find PMFBY difficult both in terms of raising the claim and getting it cleared. "For instance, farmers are mandated to report the incidence of crop loss within 48 hours. But with the existing reporting mechanism, no farmer can meet this requirement, resulting in the claim automatically becoming invalid," he added.

While it is compulsory for private insurance companies to appoint field staff as part of their outreach programme to accept claims, very few have done it. “The companies have half-heartedly set up help lines and call centres, but they are not at all helpful when it comes to reporting crop loss and making claims in time,” said Vissa.

Crop insurance is the only solace for farmers in case they don’t sow, since they are not eligible for monetary compensation for crop failure. While there’s a provision for farmers to claim insurance under ‘preventive sowing’ for failure to sow owing to elusive rain, there are instances where insurance companies have rejected the claims alleging they were false.

TOP

Source

Make enough financial allocations to make crop insurance schemes attractive for farmers: Parliamentary Panel - The Economic Times – 30th December 2018

Noting that there were several "problems", including lack of transparency, in two crop insurance schemes run by the government, a parliamentary panel has suggested making adequate financial allocations so that the schemes attract participation from a greater number of farmers.

The parliamentary panel, chaired by senior BJP leader Murli Manohar Joshi has also recommended re-formulation of agricultural insurance scheme in order to suit the needs of farmers who engage in organic farming, while also suggesting inclusion of multi-cropping system under it.

The Committee on Estimates (2018-19) in its 30th report on performance of the National Action Plan on Climate Change (NAPCC) under the Union Environment Ministry said the National Mission for Sustainable Agriculture "lacks" in focusing on farmers while taking initiatives for sustainable agriculture.

It noted that agriculture as a sustainable occupation can remain viable only if the farmers are given chance to sustain themselves and for this; they need to have access to better seeds, best farming practices and support from the government to cover risks.

It said the Pradhan MantriFasalBimaYojana (PMFBY), launched in 2016, is a yield-based insurance scheme that uses crop-cutting experiments (CCEs) to determine the yield lost by farmers due to natural catastrophes and adverse weather conditions.

The yield obtained through the CCEs determine the payout made by insurance firms to farmers and the PMFBY improves on other existing schemes by removing caps on premiums and making use of modern technology, the committee stated.

"However, the committee also notes that the scheme suffers from several problems such as the delay in crop cutting experiments and its associated high costs, delayed/non-payment of insurance claims to farmers and lack of transparency.

"As a result, farmers lose interest in the crop insurance schemes. Another problem relating to crop insurance schemes in India is coverage," the panel said in the report. It pointed out that PMFBY states that the overall area insured has decreased over the last two years (from 57.2 million hectare in 2016-17 to 47.5 million hectare in 2017-18).

This is less than 24 per cent of the gross cropped area (against a target of 40 per cent). In the US, the gross cropped area is 89 per cent and in China it is 69 per cent, the report stated. "The committee, therefore, recommends that adequate financial allocation should be made so that the crop insurance schemes attract participation from greater number of farmers.

"The committee also recommends that agricultural insurance scheme should be re-formulated in order to suit the needs of farmers who engage in organic farming. Multi-cropping system also, which is the very basis of organic farming, should also be included under the insurance schemes," it said.

The panel noted that there is another insurance scheme -- the Weather Based Crop Insurance Scheme (WBCIS) -- which aims to mitigate the hardship of the insured farmers against the likelihood of financial loss on account of anticipated crop loss resulting from weather conditions, including fluctuation in rainfall, temperature, wind and humidity.

This scheme seeks to provide insurance claims to farmers on the basis of observed weather data that are directly relevant to agriculture, the committee said. "The problem with this scheme is that the number of automatic weather stations in the country is very less. As against the requirement of 33,000 automatic weather station (AWS), only 706 AWS are operational."

"In spite of its advantages, the coverage under WBICS has declined from 11.25 million in 2014-15 to a little over 2.1 million in 2016-17. In order to increase coverage, it is necessary for the government to effectively communicate to the farmers the value of insurance products," the committee stated.

TOP

Source

MOTOR INSURANCE

Pros and cons of buying motor insurance from a car dealer - The Economic Times – 3rd January 2018

Buying car insurance through the dealer saves time but may come with its negatives. Let's see the pros and cons of buying car insurance from a car dealer. With car loans available easily, owning a car has already become an effortless affair. However, taking your prized possession out of the showroom on to the roads has to wait unless the car is insured.

Since long, car dealers have been offering insurance to buyers through a tie-up with the insurance company. Buying car insurance through the dealer itself saves time but may also come with its negatives. Let's see what are the pros and cons of buying car insurance from a car dealer.

Advantages

The process of buying car insurance from the car dealer itself will certainly save a lot of time. Otherwise, one would have to get in touch with other insurers, seek their premium figures and then decide. Here are few other advantages:

- The entire process of insurance purchase is streamlined and more convenient when it is done through a dealership.
- As the car purchase and insurance gets bundled, the buyer may receive bundling discounts on the deal. Some car dealers may waive off the first year premium, thus sweetening the deal further.
- In case one needs to go for add-ons, the dealer will be able to offer them too. In addition, few other services may also be bundled from the dealer's end.
- Most such dealers have a separate helpdesk for insurance queries and claim assistance that may be of help at the time of need.

Disadvantages

Buying insurance from a dealership has its own disadvantages:

- In some cases, the dealers have their own pre-packaged policy with lots of features thrown-in. Not all of them could be required but still one has to pay a higher than regular premium in order to get the car insured through the dealer.
- The car dealer will have tie-ups with specific insurance companies. As a customer you will be able to purchase the insurance solutions provided by these companies only.
- The car dealer may not offer the best price on insurance. So, while customers save a lot of time through this purchase, they may not really save money. Car dealers work with insurance providers on a commission basis. So, the customer may be required to pay higher premiums than what they would pay if the insurance was purchased through another mode.

- The process of buying car insurance from a dealer does not give you the opportunity to compare plans between insurers. This is, in fact, a crucial step in the process of deciding on an insurance policy.
- Dealerships may include voluntary excesses or add-on covers under your auto insurance policy without specifically highlighting it. You should be alert and read through the policy coverage carefully before signing on the dotted line. In case your policy has a high value for voluntary excess, you will be required to pay a large part of the claim amount. Having add-on coverage that is not useful to you will only result in an increase in the premium you pay, without any other benefits.

Regulatory take

In January 2018, the Insurance Regulatory Development Authority of Indian (IRDAI) had taken note of the influence of car manufacturers and the car dealers who were selling insurance and came out with this ruling - "It is reported that the Original Equipment Manufacturers- OEM's are exercising undue influence both on the insurance intermediary and the automobiles dealer who have become (Motor Insurance Service Provider (MISP) without having corresponding accountability for their actions." The regulator added, "In order to ensure that MISP guidelines work in the interest of the customers, it is advised that no MISP or the insurance intermediary can enter into an agreement with the OEM which has an influence or bearing on the sale of motor insurance policies." The move helps in bringing transparency and accountability thus befitting the buyers.

What you should do

At the showroom, the entire process of buying the car may take 2-3 days. In the meantime, explore other insurers and modes of buying including online buying. Work out the numbers post discount and see what works best for you in terms of saving time and money too.

TOP

Source

Liquidity crunch, higher insurance costs impact two-wheeler sales in Dec – The Hindu Business Line – 2nd January 2018

A liquidity crunch and increased insurance cost weighed on the sales performance of two-wheeler manufacturers in December, reflecting a mixed picture of the industry.

While Hero Honda and Royal Enfield saw contraction in sales volumes in December 2018 on a year-on-year basis, the other biggies, such as Bajaj Auto and TVS Motor Company, recorded growth in varying degrees. Suzuki Motorcycle India witnessed strong growth.

Market leader Hero Moto Cop on Wednesday reported a 4 per cent decrease in its December sales YoY to 4, 53,985 units, compared with 4,72,731 units in the corresponding month in 2017.

Two-wheeler sales: Mixed bag

	Dec 2018	Dec 2017	% change
Hero MotoCorp	4,53,985	4,72,731	-4
Bajaj Auto	1,57,252	1,12,930	39
TVS Motor Company	2,09,906	2,07,739	1
Royal Enfield	56,026	65,367	-14
Suzuki Motorcycle	43,874	32,786	34

The increased cost of two-wheeler insurance ahead of the Diwali season, and the prevailing liquidity crunch in the market, impacted the overall growth momentum in the industry during the third quarter, according to Hero MotoCop.

Currency volatility

"The year 2018 was a challenging one for the global economy," said Pawan Munjal, Chairman, Managing Director and Chief Executive Officer, Hero MotoCorp. "While the continuing volatility in currency and commodities slowed down the pace of growth, the global geopolitical and trade conflicts also affected sentiments in markets and industries across the world."

Transition to BS-VI

He said the cost of two-wheelers will further go up once the new set of safety regulations comes into force, followed by the transition to BS-VI emission norms. All these will put severe stress on the cost-sensitive segments, he added.

Munjal also pitched for a reduction in GST rates. "Given that two-wheelers provide basic mobility to the masses, there is an urgent need to reduce the GST rate from the 28 per cent bracket of 'luxury goods' to that of 18 per cent for mass usage items," he said.

Going forward, he said, the industry expects a turnaround in the fourth quarter with improved liquidity in the market and the upcoming festival season in many parts of the country. Meanwhile, Bajaj Auto reported a 39 per cent jump YoY in its domestic motorcycle sales in December to 1, 57,252 units, against 1, 12,930 units in December 2017.

Suzuki Motorcycle India reported 34 per cent growth YoY to 43,874 units from 32,786 units. However, TVS Motor saw just marginal growth, at 2, 09,906 units, during December 2018, against 2, 07,739 units in December 2017. Scooter major Honda Motorcycle & Scooter India said it will declare its sales numbers on Friday as the company is closed till then.

TOP

Source

OPINION

Maternity Benefit Act still left with gaps: Female labour force participation slumps further - Financial Express – 4th January 2018

Ambedkar said, "I measure the progress of a community by the degree of progress which women have achieved". Today, India aims to be an economic superpower with the fastest growing economy; hence the case for change to improve women labour force participation has never been stronger. According to the World Bank, India ranks 120 amongst 131 countries in female labour force participation rates. It is no more just a debate of social equality and women's independence, but about economic progress as well.

In India, women constitute 48.5% of the total population however 96% of working women are employed in the informal sector.

India's female labour force participation rose to 31% when we started reforms in 1991. It then dropped abysmally low to 19% and it is now up to 26%, which is less than half of China's 60%. As per the research conducted by McKinsey in 2015, statistics reveal that India can increase its 2025 gross domestic product (GDP), estimated at $4.83 trillion, by anywhere between 16% and 60% by increasing women participation in the labour market.

At the same time, no single policy measure can improve the outcomes for women in India. When The Maternity Benefit Act was amended in 2017 to increase maternity leave entitlement from 12 weeks to 26 weeks for the first two children, it had two objectives—prevent declining women labour force participation and improve the quality of labour market opportunities.

However, good intentions don't always make good laws. While seemingly reformist, by placing the responsibility of providing benefits solely on the employer, it turned the tide and woman participation in the labour force further slumped.

Manufacturing (estimated at 23,266 lakh), education (estimated at 14,494 lakh) and retail (estimated at 12,450 lakh) are the top three sectors with the highest number of female workforce participation in India and, keeping in mind the amendments of the Maternity Benefit Act, it can lead to significant job losses.

Most start-ups, SMEs and medium-sized multinationals perceive the amendment as a deterrent and are likely to reduce their intake of women. Given the growth challenges, resource constraints and margin pressures, the forecasted job losses in sectors like manufacturing and retail are expected to be between

3-5%, while real estate will see a moderate job loss of 1-2.5%. Sectors like IT/ITES, e-commerce and BFSI have witnessed a positive impact and are expected to have a constructive demand in the next fiscal as well.

A 2014 ILO report on maternity laws and practices around the world states that 58% of all countries, including Brazil, Russia and South Africa provide paid maternity leave funded through social security, and around 16% of countries fund the same where costs are shared jointly by the employer and the state. Only 25% of all countries impose the funding liability solely on the employer. The government should consider some measures for mitigating the limitations, which could be through themselves funding the costs partially through public funds, tax rebates for maternity wages or by the setting up of an insurance scheme to pay maternity wages and the consequent sharing of the premium with the employer. Another option could be to break up the 26 weeks into 13 months of maternity and 13 months of paternity leave, in an effort to negate any possibility of gender bias where work is being shared equally by both parents.

The government is evidently aware of the unintended consequences of the well-meaning amendments. However, the recent changes proposed in the yet to be finalised policy by the ministry of labour and employment still have some gaps. The policy aims to reimburse only 7 weeks, out of the 26 weeks, to employers with a wage restriction of less than `15,000. On the other hand, the ESIC Act mandates that all employees earning wages of `21,000 or less shall be covered under the ESIC Act, which means that women earning wages of `21,000 or less, who are employed in non-implemented areas, shall not be entitled to benefits.

The government should also set up crèches with all the attendant facilities as proposed in the Maternity Benefit (Amendment) Act 2017 and allow employees eligible for such benefits to use these "crèches" at a nominal cost. To maintain uniformity and balance, it would be advisable to bring the Maternity Benefit Act under Central legislation.

To conclude, empowering women and providing fair representation will play a vital role in the economic growth and sustainable development of our country. In the absence of support from the government, timely intervention or necessary incentives the Endeavour will remain unfulfilled. As long as half the population of India is at a disadvantage in the labour ecosystem, it is imperative for concerted efforts, both from the government and the industry, to allow more women to participate and to promote decent work opportunities for women across social strata.

(Opinion given by Rituparna Chakraborty)

TOP

Source

Life insurance policyholders to get digital delight in 2019 - Financial Express – 2nd January 2019

The advent of a new year always comes with promise, and 2019 has the potential to be a very promising year for life insurance in India. The world's fastest growing large economy with a burgeoning pool of customers, strong macro-economic factors and a robust financial ecosystem make the ideal backdrop to take the life insurance sector to the next level.

The traditional Indian family has undergone a significant evolution over the last few years. The expectations of young customers from service providers are pushing companies across sectors to work smarter, deliver faster and engage better to not only be preferred but to be loved by this set.

Digital drive

The government's drive towards digitalisation and a cashless economy has seen in the last few years a steady movement from physical assets such as property and gold, towards financial assets. Adding further impetus is the heightened awareness around insurance in general, thanks to government schemes such as Ayushman Bharat for health insurance, Pradhan MantriJiwanJyotiBimaYojana (PMJJBY) for life insurance, Pradhan Mantri Suraksha Bima Yojana for accidental death and disability insurance

and the Atal Pension Scheme for retirement planning. This is moving the country towards a culture of securing the future of one and one's family, which is the most fundamental job of life insurance.

As an industry, there has never been a greater digital drive to harness the power of data and analytics, to digitise the customer's journey and to enable the life insurance seller to work smarter and more efficiently. Moving way ahead of just B2C or e-commerce, today the life insurance sector is weaving on digital looms to integrate the online and the offline and create a beautiful fabric of seamless customer experience.

From expanding distribution networks, identifying individual customer needs, simplifying documentation and underwriting processes and aiding agent advisors with sound advice based on sophisticated analytics, AI and machine learning, the industry is best poised now to revolutionise its processes through digital interventions.

Reaching customers

On the retail front, life insurers are innovating to reach out to customers at their fingertips and reduce time to issue a policy. I see a great scope going ahead on taking these conversations going and meaningfully engaging with customers through the tenure of their policies, so as to drive persistency ratios further upward.

So how's this reset moment going to manifest itself for the industry? Despite a steady expected growth of 12-15% CAGR growth for the sector over the last couple of years, we still see life insurance penetration standing only at 2.72%, as against a global average of 3.47%. What the industry will see going ahead is in my belief the holy trinity of life insurance: protection power, consultative selling stars and digital delight.

We continue to be one of the most underinsured countries and the "protection gap" as per some estimates is at `489 trillion. The industry sum assured grew by 36% CAGR between 2001-10, however, the same grew at only 22% CAGR between 2010-18. These points to the enormous headroom to further protect the country, and I believe many insurers will be focusing on increasing their share of protection and educating customers on the need to protect one's family through life insurance.

The agent advisor has globally been the support pillar to any life insurer. In the coming months I would expect to see an Agent 2.0, digitally enabled, more efficient and smarter in approach. The role of the agent advisor will undergo a change from merely being a seller of life insurance to being a financial portfolio manager, backed with the power of deep data analytics and equipped with the tools to save time, costs and increase efficiency.

Digital delight is what I believe will be the outcome of all the above. A frictionless journey for a customer from prospecting to purchase to service and finally to claims settlement is what will delight the customer. This will only be possible when the all three elements of the trinity work in tandem and synergize to take the industry to the next level.

(The writer is managing director and CEO, Max Life Insurance)

TOP

Source

Five insurance covers for 2019 – Mint – 2nd January 2018

Risks can impact us, our family and our assets. The risks can be in form health emergencies, accidents, loss of valuables, damages to assets. Here are five types of insurance cover that you should consider in the coming year:

Health insurance

Healthcare costs are increasing at a rate of 15-20% annually. The best way to deal with healthcare risks is being prepared financially. You should go for a threepronged approach. At the base will be a holistic health cover with a base cover that promises enough sum assured that can take care of the needs of you and your family. On top of this, there should be a top-up plan that gives you an even bigger sum assured cover at a fraction of the cost. You may also want to consider critical illness cover.

Term insurance
Human life value is immeasurable. In your absence, all such investments will not see any new addition and that makes them weaker in terms of protecting the financial goals of your family. Term insurance is the most affordable insurance policy that gives you big cover, say Rs2 crore, at an affordable annual premium. It is a simple contract that is triggered in case you meet with an unfortunate and premature event like death.

Home and content insurance
People spend hundreds of lakhs in buying their dream home today. Nestled inside gated communities with all the modern amenities, our home is our pride.

However, a simple thing like a home and content insurance makes sure that your 20-30 years of labour doesn't go waste because of a catastrophic event. We are prone to natural and man-made catastrophes. Our homes also account for a significant part of our investments. Hence, protecting these financial assets along with all the contents inside is important. Home insurance covers your house from various dangers like accidents, perils, and thefts. Content cover ensures protection for electronic items like TVS, mobile phones and electric/ electronic appliances and equipment in your house.

Standalone personal accident cover
Outside the comfort of our homes is a world filled with rash drivers, potholes and unforeseen situations. Minor accidents are not worthy of protection, but major ones can leave you crippled, and severely affect how you and your family live from here on. Better to be safe than sorry. With a standalone personal accident insurance cover, get local and global protection against such possible events. Get full cover for accidental death, permanent or partial disability, and even medical expenses extension in some policies if you or any family covered family member meets with an accident. From January 1, a person with two or more cars can now buy a single compulsory personal accident cover and get protection to all the vehicles driven by the policyholder.

Cyber risk insurance
A typical person today spends more time on the digital superhighway than on the roads. This also exposes him/her to cyber risks. Unlike a pickpocket who actually can be caught after the act, in the cyber world attackers and perpetrators are unknown and remain hidden. With mere access to banking details and data stored online, serious financial loss can be inflicted upon you.

Reports of phishing, identity theft, cyberstalking, harassment and hacking of bank accounts are not reserved just for the wealthy. A cyber risk insurance cover offers protection against such perils.

(The writer is Anil Rego is chief executive officer and founder, Right Horizons)

TOP

Source

ULIPs: A holistic risk management tool – The Economic Times – 2nd January 2018

In the context of financial instruments, the commonly used phrase "having your cake and eating it too" goes well with ULIPs or Unit-Linked Insurance Plans.

When we think of risks, we only associate with physical risks (death, disability, critical illness). The risks of market volatility and lack of financial discipline are real, significant, and often, unacknowledged. ULIPs allow for management of all these three risks due to the insurance cover, policy lock-in (to prevent impulse spends from funds put aside for long-term needs) and investment options of automatic profit bookings, fund options and fund switching provisions.

The smartphone is perhaps a good anecdotal comparison, to explain how ULIPs extend themselves to multiple objectives of financial planning and risk management. Akin to the smartphone, that incorporates several capabilities into a nifty, handheld device with a built-in camera, utility applications to book cabs, online wallets etc., ULIPs too pack in a host of benefits for its customers.

The multifaceted ULIP allows for flexibility of investment, based on return expectations and risk appetite. One can invest in debt or equity — or simply schedule investments to shift between the two, depending on age or return triggers, as per one's tailored preferences. ULIPs' in-built aspect is the life insurance cover. The cover is significantly higher than the invested amount in the initial years, to fit individual life goals. Eventually, with a built-up corpus, charges for the life cover are also exempted, making this a cost-efficient proposition.

ULIPs, while helping one stay on the financial discipline pathway, gives one the option of withdrawal or adding onto the corpus over the longer term, as well. ULIPs have an in-built agility to cater to evolving needs of a customer through enabling switches between asset classes to book returns, scheduling systematic withdrawals to supplement income, or enhancing investments during earning years for a given future goal. This makes the plan a holistic 'partner for life', all through one's financial journey of accumulation, growth and systematic withdrawals. Further, the convenience is unparalleled with cumbersome documentation or tax implications taken out of the picture when one buys a ULIP.

Since there is the aspect of regulated and defined reduction in yield, the value for money element is taken care of. ULIPs coupled with term cover work out cheaper than investing through a mutual fund over the longer term. Besides, an insurance company is inherently wired to maintain its customers' financial stability, making it one of the more reliable customer investments.

While creating plans for life goals, the commitment of the ULIP provider to stay throughout the life of the policy is critical. ULIPs, by virtue of regulation, do not have any call options. That means the plans will be serviced as a promise made for life.

It won't be a stretch to refer to the ULIP as the unacknowledged soldier capable of morphing itself to cater to the needs of simplicity, ease, agility, and as a protector against risks.

New Year resolutions revolve around sticking to commitments made towards fulfilling cherished goals and dreams. In tandem with the hard work involved in making a lasting and long-term impact, there is an able and supporting aide in the ULIP, to structure one's financial plans in a single place while delivering not only value for money, but also peace of mind.

(Author is managing director, India First Life Insurance)

TOP

Source

PM-JAY: Can it rise to the challenge? – Financial Express – 31st December 2018

What if you try making a bullet train operational in India within a year? The project will fail miserably as you need to allow enough time for design and implementation. Using the same logic, if a road needs repairing, it needs to be fixed immediately, instead of wasting time in endless deliberations. It applies both ways.

Adopting a short-term approach to dealing with longer-term projects is just as wrong as adopting a longer-term approach to solving problems requiring immediate response. Yet these approaches are adopted for strategic reasons.

Roll it out thoughtfully

Take the case of the Pradhan Mantri Jan ArogyaYojana (PMJAY)—the programme that aims to provide financial protection to 100 million poor households against hospitalisation expenses—that Narendra Modi launched in September this year. Even though the NDA government had announced its intent almost two years ago, the launch of the PMJAY was timed closer to the forthcoming general elections. As a result, the programme is now being rolled out hurriedly, even before the necessary systems and processes have been developed fully and tested for their robustness. The government wants to show some quick results before the elections. So, the programme is chasing, tracking and reporting the number of people who benefited from it. Its design and implementation are happening almost side by side!

Just because one is open to iterative or adaptive learning doesn't mean a design is a good starting point. One needs to aim to minimise iterations/adaptations. Which means that one needs to start with as good a design as possible. Too much iteration too often can make the stakeholders lose confidence in the programme. Clearly, the design of systems and processes under the PMJAY should have started earlier on.

Good solutions that are designed hurriedly and implemented imperfectly can make them look bad. Continuing with the PMJAY example, providing financial protection against hospitalisation expenses is a good solution to reducing household spends on hospital care. Yet the imperatives of rolling out could potentially bring a bad name to the programme and its key stakeholders, as well as discredit the solution. The package rates being given to the empanelled hospitals remains a vexed area. A clear vision and understanding on the package rates are yet to evolve, not to mention a binding commitment to uphold sound principles in rate revision.

Although the National Health Agency has done a splendid job in putting several guidelines in place to enable states to roll out the programme, some key questions remain unanswered: How does the programme propose to level the playing field between the public and private hospitals, as public hospitals would continue receiving budgetary support? Whether the programme will be extended to the above-poverty-line (APL) population in the unorganised sector? Will additional incentives be given to the private players for setting up hospitals in the underserved areas in due course? And these questions are not independent; they are interconnected.

Covering the APL?

Even with the PMJAY at scale, a sizeable part would remain uninsured—mostly lower-middle class and middle-class households whose income-earning members work in the unorganised sector. Of course, these households have an option to buy health insurance product from one of the insurance companies. But the product would typically be priced several multiples of the price these households could be covered for under the PMJAY. Additionally, health insurance products would likely have several exclusions.

Bringing this section of population also under the fold of the PMJAY upon payment of premium will bring significant value. It has other important advantages for the programme. For example, the budgetary support to public hospitals could be reduced, thereby levelling the playing field with the empanelled private hospitals.

Further, it would give correct signals to the private players who want to invest in hospitals in the underserved areas. The APL population need not be included immediately but, say, in a couple of years. What is needed at this stage is only a binding policy commitment so as to reduce policy uncertainty and enable investments in hospital infrastructure. In other words, a longer-term outlook is needed, and based on this, certain commitments are warranted now.

Will not bringing of the APL under the PMJAY reduce the potential market for insurance companies? Yes, it would, but only for the basic minimum health insurance cover. For supplementary or add-on health insurance cover, people will have to turn to insurance companies. In a growing economy, the rising economic prosperity of its people will boost demand for supplementary health insurance cover. Insurance companies will still have expanding health insurance business; only that the type of products will be different.

To sum up, it is important to make longer-term commitments and resolve programme uncertainties, especially with regard to the inclusion of the APL, for which there is a strong case. Let such commitment and clarity not be guided by political interests alone. Drawing a clear boundary between political interests and professional conduct is in the best interest of the programme.

(The author is a development economist, formerly with the Bill & Melinda Gates Foundation and the World Bank)

Source

TOP

INTERVIEW

HIV, mental illness coverage may not hike premiums sharply: Pushan Mahapatra, SBI General Insurance - The Economic Times – 31st December 2018

"The move by the regulator towards long-term policies is being watched in other insurance markets," Pushan Mahapatra MD & CEO, SBI General Insurance.

Thanks to analytics based on AI, insurers can use traditional risk analysis more efficiently, isolate frauds and provide better products at better prices to customers, Pushan Mahapatra tells ET Wealth.

Are regulatory and court rulings related to coverage for mental illness and HIV-positive individuals likely to push up overall health insurance premiums?
Mental illness and HIV/AIDS are either partially or completely excluded under most health policies. To this extent, providing coverage for these conditions could result in some premium increase. However, concerns that premiums might skyrocket may be unwarranted as insurers price their products on portfolio basis. If data reveals that incidence of these conditions is on the lower side, then premium increases, if any, may be moderate.

Will proposals put forth by the working group on standardisation of health insurance exclusions have a similar effect, if finalised?
The working group has acknowledged the possibility that its recommendations would have some effect on pricing of the respective products. The working group's terms of reference include rationalising the exclusions under health insurance policies by minimising the number so as to enhance the scope of health coverage. Hence, if the recommendations are accepted in toto by the regulator, there is a possibility of increase in health insurance premiums.

What are your views on the working group's proposals? What are the key highimpact changes from a policyholder's point of view?
The working group's proposals are a welcome attempt to bring an element of standardisation in health insurance policies, specifically on exclusions. The working group has made several recommendations which are customer-friendly. For instance, no permanent exclusion for diseases contracted after buying a policy, prescribing a list of exclusions with uniform standard wording to be used by all insurers as well as list of exclusions that should not be allowed in health insurance policies. Another key recommendation relates to the formation of a Health Technology Assessment Committee to examine and recommend the inclusion of advancements in medical technology as also new treatment procedures and drugs introduced in the market.

It's been nearly four months since the longterm motor insurance policy rules came into effect. What has been the response from customers? Which combination has emerged as the most popular one? Initial trends suggest that long-term combination of own damage (OD) and third party (TP) covers are proving quite popular in the two-wheeler segment. However, in the case of private cars, we have observed that oneyear OD cover with three- year TP cover is preferred as the OD component of premium will be quite high if the customer opts for paying three years' premium upfront.

These rules, along with the compulsory personal accident cover, have resulted in frontloading of costs for customers. What kind of long-term impact do you foresee?
While it is true that long-term policies will result in higher outgo in the first instance, a customer will also be protected against any increases in premium over a period of three or five years. It eliminates the requirement of yearly policy renewal at least for the third-party component. Hence, there are some benefits of longterm insurance policies. At this stage, it would be premature to speculate on the long-term impact as we need to wait and see. However, it needs to be borne in mind that annual renewable policies are the norm in almost every country and the move by the regulator in India towards long-term policies is being watched with interest in other insurance markets.

What kind of product and service innovations can motor and health insurance customers expect in 2019?

Usage-based pricing with emphasis on telematics could be another innovation in motor insurance as it is quite common in more mature markets. Utilisation of technology in claims settlement would be another key differentiator. In health insurance, disease or illness-specific products as well as products catering to OPD or dental treatment expenses will see greater traction.

Many general insurers are investing heavily in technology. What benefits can policyholders expect from these measures?

These are exciting times—we have technology that is usable, relevant and can be replicated across industries. The insurance industry has often been branded as a late bloomer in technology, but with adoption of digital technologies, these innovations are a reality and no longer just white papers.

We are able to combine traditional risk analysis with analytics based on artificial intelligence much more efficiently, isolate frauds and provide a better product at a better price to our consumers. Machine learning gives us the capability to increase operational efficiency and expedite decision-making. I can offer quicker servicing to my customers—be it policy issuance or claim payments.

TOP

Source

INSURANCE CASES

Mediclaim policyholders can seek interest for delay in claim payment – The Economic Times – 31st December 2018

Ruling in favour of a woman who was reimbursed almost three years after her claim, the commission said that she was entitled to 9% interest on the amount.

While New India Assurance Co Ltd had initially rejected her claim, she finally received the money in 2013 after an insurance ombudsman ruled in her favour.

Setting aside a district forum order, the Maharashtra State Consumer Disputes Redressal Commission said that it had not considered all the facts in a proper manner and wrongly came to the conclusion that the complainant had accepted the amount towards the full and final satisfaction of her claim and hence, was not entitled to get interest on that amount, along with costs and compensation.

"Opponent (New India Assurance Co Ltd) has not produced any document on record to show that complainant had received the amount towards full and final satisfaction of her claim, thus waiving her right to get interest on that amount along with costs and compensation.

As she has received this amount after about three years, she is entitled to get interest on that amount," the state consumer commission said.

The commission also ordered New India Assurance Co Ltd to pay her Rs 30,000 as compensation and costs of the complaint. The woman submitted an appeal before the state commission in 2017 after a district forum rejected her complaint in December 2016.

She said that she was admitted to the hospital between April 26 and 30, 2011, and underwent ovarian surgery. She said after her claim was rejected on October 15, 2013, an insurance ombudsman ordered the insurance company to pay her the amount. In December 2013, she received the cheque from the company. She encashed the cheque.

Then, in February 2014, she gave a letter to the insurance company alleging that as her claim was given after three years, she is entitled to get interest on the amount of her claim, along with costs and compensation. When the insurance company refused this, she filed a consumer complaint.

TOP

Source

Pay interest for Mediclaim payout delay: Consumer body to firm – The Free Press Journal – 31st December 2018

The Maharashtra State Consumer Disputes Redressal Commission has ruled that mediclaim policy holders can claim interest if there is a delay in receiving reimbursement. The consumer panel's bench comprising president A P Bhangale and member D R Shirasao was hearing a plea filed by a woman seeking interest on Rs 1.67 lakh reimbursement received by her for an ovarian surgery almost three years after filing claim.

In the order passed recently, the commission held that the woman was entitled to nine per cent interest on the amount. According to the consumer panel order, the woman had availed medical insurance from New India Assurance Co Ltd. During the subsistence of the insurance policy, she underwent an ovarian cystectomy in April 2011.

After discharge, she made a claim for hospitalisation charges which the insurance company repudiated. The woman then approached the insurance ombudsman, who in October, 2013 directed the insurance company to settle the claim of the woman. Thereafter, the company paid her the claimed amount of Rs 1.67 lakh.

The woman, after encashing the amount, wrote a letter to the company seeking interest on the reimbursement due to delay. When the company refused to pay the interest amount, she filed a consumer complaint.

The state consumer panel in its order noted that the insurance ombudsman had only directed the insurance company to give the claim of the opponent. "There is no reference in respect of giving interest on the amount of claim and costs and compensation to the complainant," the panel said.

"The opponent (insurance company) has not produced any document on record to show that the complainant had received the amount of Rs 1,67,152 towards full and final satisfaction of her claim waiving her right to get interest on that amount along with costs and compensation," the order said.

The panel held that as the woman received the mediclaim amount after around three years, she is entitled to get interest on it. "She (complainant) was also required to approach the insurance ombudsman for getting that claim from the opponent and hence, she is entitled to get compensation along with costs of litigation," the panel held.

The panel ordered the insurance company to pay the woman interest at the rate of nine per cent from April 2011 to December 2013, adding that this amount will have to be paid within a period of two months. "The opponent shall also pay a sum of Rs 25,000 as compensation to the woman and Rs 5,000 towards litigation cost," the panel ordered.

TOP

Source

Insurance firm told to pay Rs 80,000 for rejecting claim for dead cow – The Times of India – 30th December 2018

A district consumer disputes redressal forum has directed an insurance company to pay Rs 10,000 as compensation for rejecting a claim. The company was also told to settle the claim amounting to Rs 70,000.

The complainant, owner of Haryana Dairy Farms in Dehri village, Ambala, told court that he had purchased 10 cows through State Bank of India, Panchkula, from October 11, 2013 till October 10, 2016. The complainant said on December 16, 2015, one of the cows died. The complainant informed the insurance company about the same and on the same day a doctor was appointed to investigate the case. He examined the dead cow, took its photographs and tried to take data from the microchip attached to the animal. It has been learned that the chip failed to respond.

It was told that the complainant after the inspection handed over documents to the doctor, but the same were returned to him on January 21, 2016, stating that investigation report has already been filed at the company's regional office and the documents, if any, should be submitted directly. Following this, the complainant submitted the documents to the regional office along with a letter dated January 25, 2016. In the letter, he had explained the reason for the delays in submitting the documents.

The insurance company in its reply had stated that the doctor during the inspection did not find any chip on the cow and the entire process was done in the presence of the complainant. It was further stated that the investigator asked the complainant to give clarification over the missing chip, however he couldn't.

The forum was told that the regional office asked the complainant multiple times to send relevant documents to avail the claim, but he failed to respond. The company said that complainant also failed to submit the microchip.

To this, the complainant said that the microchip was taken by the doctor at the time of inspection. Forum after hearing both the sides held that the company failed to place on record the investigation report to support averments made in the written reply.

"Otherwise also, in our considered view if the microchip was not found from the dead cow even then the identification of the insured cattle could have been easily carried out by the investigator through ear tag, colour and breed of the dead cow," forum said.

TOP

Source

Insurance firm fined for repudiating claim – The Tribune – 29th December 2018

On a complaint filed by Raj Kumar, a resident of Master Tara Singh Nagar, the District Consumer Disputes Redressal Forum, has penalised Apollo Munich Health Insurance Company Limited for refusing claim to the complainant.

The company was fined Rs 43,055. The complainant had obtained the 'Health Insurance Mediclaim Optima Restore Floater Policy' in 2015 and got it renewed from September 5, 2016, to September 4, 2017. Under the policy, the wife and the son of the complainant were also covered with a sum of Rs 3 lakh.

On January 23, 2017, Raj Kumar complained of palpitations (fast heartbeat) and was admitted to Care Max Super Speciality Hospital, Jalandhar, and discharged on January 25, 2017.

The matter was reported to the company and the complainant lodged a claim for Rs 33,055 for medical treatment. He presented prescribed claim forms, bills, receipts, discharge certificate, along with clinical test, to the insurance firm.

The complainant said despite having submitted the required documents and certificates issued by the doctor, the firm rejected the claim on the grounds that he was diagnosed with sleep apnea and underwent the treatment for the same, which was excluded from the insurance policy.

The complainant stated that he was admitted to the hospital for the treatment of palpitations and was diagnosed with sleep apnea later and he hold certificate and discharge papers issued by the hospital that says he was treated for palpitations not sleep apnea.

The firm in its reply to the forum averred that on February 1, 2017, a reimbursement claim was submitted on behalf of the complainant for the reimbursement of Rs 33,055. But as per their investigation from the hospital and from available documents, they found that the complainant was admitted for the management of diabetes mellitus, palpitations, sleep apnea and underwent sleep study and later, the patient was discharged.

The firm said after post-scrutiny of the documents, it was noticed that the patient was admitted with palpitations during hospitalisation but he had underwent treatment for sleep apnea. The claim was

rightly rejected as the disease of sleep apnea was excluded from the health insurance policy taken by the complainant.

The order
The forum, in its reply, after verifying from the treating doctor, HS Dhingra, who admitted that the complainant was hospitalised at Care Max Super Speciality Hospital, Jalandhar, with palpitations and accordingly, he was treated for it.

It stated that it was cleared from the documents of the hospital that initially the complainant was admitted to the hospital for the treatment of palpitations and was not admitted for the treatment of sleep apnea.

The forum added that there was no intentional or wilful suppression of any fact by the complainant, prejudicial to the terms and conditions of the policy.

The forum, thus, ordered to the insurance firm to repay an amount of Rs 33,055, along with compensatory cost of Rs 7,000 and litigation cost of Rs 3,000, to the complainant.

TOP

Source

SURVEY & REPORTS

Indians use traditional insurance plans as investment tools: Survey – The Economic Times – 31st December 2018

A majority relies on life insurance plans for long-term goals, finds Exide Life's Money Habits Survey 2018. The survey polled 2,408 respondents in the age group of 30-60 years across 12 cities. Figures do not add up to 100 due to multiple responses.

I. Life insurance rules the roost
Despite low returns, life insurance plans are use to achieve primary goals

What is your source of funding to buy a house?
43% Life insurance
31% Bank savings
31% Mutual funds
26% Fixed deposits
22% Provident Fund

...to build a retirement corpus
49% Life insurance
34% Provident Fund
27% Mutual funds
21% Bank savings
24% Fixed deposits

...to fund kids' education
38% Life insurance
29% Bank savings
28% Fixed deposits
25% Mutual funds
15% Provident Fund

...to fund kids' weddings
29% Fixed deposits
28% Life insurance
24% Mutual funds

24% Gold
19% Bank savings

...to create a legacy
50% Life insurance
30% Real estate
25% Bank savings
23% Fixed deposits
23% Gold

II. Life coverage is inadequate
One in three has no idea what ideal life cover should be. Their current cover is half the ideal requirement.

Rs 20 lakh is the average life cover of those earning between Rs 2.5 lakh and Rs 5 lakh per annum.
Rs 30 lakh is the average life cover of those earning between Rs 5 lakh and Rs 10 lakh per annum.
Rs 50 lakh is the average life cover of those earning Rs 10 lakh a year and above

III. Self assessment of coverage overestimates preparedness
Nearly one in three feels he has enough to take care of his family, but many have no cover at all.

58% Feel they have adequate life cover through term insurance.
31% Feel they have enough assets to take care of their families
12% are planning to buy a term cover in the near future.
37% Of those earning less than Rs 5 lakh have no idea about life cover.
12% Do not have any life insurance

IV. Not too many are writing wills
Despite awareness about importance of leaving a will, execution remains low.

13% have executed a will.
14% haven't heard about a will.
72% have heard about, but haven't executed a will.
81% are saving and investing to build legacy corpus
14% have executed a will.

V. Digital documentation gets a thumbs up
Many have adopted digital modes to store critical documents.

45% maintain a scanned copy of key documents on their laptops or desktops.
39% store photos of documents on their mobile phones.
27% carry the documents with them in their bags or wallets.
13% use government apps like Umang or Digi Locker to store them.

TOP

Source

PENSION

EPF rate hike likely in bonanza for salaried employees – Mint – 2nd January 2018

Retirement fund manager Employees' Provident Fund Organisation (EPFO) may raise interest rates from the current level of 8.55%, bringing cheer to millions of employees in the organized sector. If indeed EPFO does follow through, it will serve up another sop in poll-bound India, this time for the salaried employees. So far, farmers—through farm loan waivers—have been the beneficiaries, while the middle class has gained indirectly, with the recent reduction in goods and services tax (GST) rates on several consumer goods.

Though the annual internal review is yet to be concluded, three officials with knowledge of the development said there was a good chance the EPF rate would be hiked. At the least, it will be retained at the existing level; given the steep fall in inflation, the real rates of interest accruing to the salaried classes have spiked.

In 2017-18, EPF savings earned 8.55% interest, which was at a five-year low. However, in 2018-19, even an unchanged interest rate will make it one of the most rewarding savings schemes. In 2018, the average interest rate of the Public Provident Fund (PPF) and the National Savings Certificate (NSC) was 7.7%. The leading ultra short-term debt funds, which invest in securities with maturities between three and six months, returned an average of 7.78%, Mint reported on Monday.

"2018 has been a relatively low-yielding year for debt investments, but the EPFO is unlikely to revise the interest rate downward for 2018-19 from what it paid last fiscal," said one of the two officials cited earlier. "It's an important year and we are making the last round of calculations before announcing the EPF rate in late January."

Prabhakar Banasure, a member of EPFO's central board of trustees, confirmed that there was little scope for reducing the interest rate and asserted that efforts would be made to increase the return for subscribers.

"We are exploring whether we can offer interest rate of more than 8.55% this financial year. Reduction of the rate is a complete no at this point in time, though the final calculation and accounts audits are still on." Banasure is also a member of the finance advisory committee of EPFO.

EPFO has an active subscriber base of more than 60 million and manages retirement savings of over Rs11 trillion. The second government official cited earlier said that though the EPF interest rate is typically declared in December, the slight delay this time was because the account audit was still on.

It will be announced ahead of the vote on account expected on 1 February. When the retirement body offered an 8.55% rate last year, it had a surplus of Rs600 crore. The third official said that EPFO's equity investments have a notional return of around 12% and might be used if required.

At present, the Employees' Provident Fund Organisation has invested around Rs50,000 crore in the stock market through exchange-traded funds. To be sure, a final decision will be taken by the EPFO central board in late January.

The official added that the EPF interest rate for 2018-19 would be in line with what the government had announced in recent times—a nearly 50% hike in incentives for front-line health workers, including those working at Integrated Child Development Scheme centres (anganwadis) and the decision to make the National Pension System (NPS) withdrawals tax-free.

In a way, all this is to please the salaried middle class. The centre has already increased incentives for millions of front-line health workers, besides making national pension system, or NPS, tax-exempt, so that the entire 60% of the accumulated corpus that a subscriber can withdraw on maturity is tax-free.

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Source

PPF regains the crown with best returns – The Economic Times – 2nd January 2018

Benefitted from the high policy rates PPF regained its pole position this year with an annual post-tax return of 7.7 per cent. Risk shunners won and thumbed their noses at equity investors in 2018. The Public Provident Fund (PPF), the one true friend of many middle-class Indians, regained its pole position this year with an annual post-tax return of 7.7%.

The National Savings Certificate (NSC) also returned 7.7%, but post tax, PPF turns out better. For the guaranteed return-seeking investor, there were several other products that did well in this space. The top five ultra-short-term debt funds, which invest in securities with maturities between three months and six months, returned an average of 7.78%, but this was not a guaranteed return.

It was a year when it paid to play safe. But the reason for high returns in guaranteed income products was also one of the causes for conflict between the government and the Reserve Bank of India (RBI). Anticipating that inflation would quicken, RBI kept policy rates high, impacting the rates on 10-year government securities (GSec). That, in turn, influenced returns on a whole raft of products that are benchmarked to the GSec rate.

For example, the PPF rate is always 25 basis points higher than the 10-year G-Sec rate. Other products too benefited from the high policy rates and with inflation at 4.74%, the real return (the extra return over inflation) remained very high for fixed-income products. "The RBI hiked policy rates in 2018 in response to the MPC's (monetary policy committee's) stance on inflation and liquidity. Well-capitalised banks raised fixed deposit rates to accommodate the expansion seen in credit growth," said Rajiv Anand, executive director of Axis Bank on the sequence of RBI's actions; real returns from financial products whose yields are affected by policy rates, including fixed deposits and small savings schemes, rose. With inflation below 4%, the bias for real and nominal rates is to the downside."

In contrast, it was a bad year for stock pickers, with mid-and small-cap shares falling sharply. The National Stock Exchange's Nifty index gained 2.69%, generating a negative return post inflation.

"In 2018, we observed some payback as volatility returned on the back of global and domestic headwinds, particularly higher interest rates, jump in oil prices and large foreign outflows," said Manish Gunwani, chief investment officer - equity investment, Reliance Nippon Life Asset Management.

Investors who looked at last year's winner did badly. The one year total return on Nifty Midcap 100 index in 2017 was 49%, making fixed deposits and PPF look poor investments in comparison. Investors in 2019, who look at 2018 returns and rush to invest in PPF, fixed deposits and gold, may be making a similar mistake. Instead, a well-balanced portfolio with some investments in safe products and some in equity would be a better choice.

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Source

EPFO may give subscribers option to increase stock investments in new year – Financial Express – 31st December 2018

Subscribers of the retirement fund body EPFO may get an option in the New Year to invest more of their savings in equity market, besides a host of other social security benefits and digital tools to manage their funds. At present, the Employees' Provident Fund Organisation (EPFO) invests up to 15 per cent of its investible deposits into the exchange traded funds (ETFs) and so far such investments total about Rs 55,000 crore. However, the ETF investments do not reflect in members' account and they do not have an option to increase the proportion of their retirement savings to be invested into stocks.

The EEFO is now developing software that would help show retirement savings in cash and ETFs components separately. At present the account only shows the savings as gross cash component. Once the cash and ETF components are shown separately in the EPF accounts, the next big leap for the EPFO would be to give an option to subscribers to increase or decrease investments in stocks. Earlier this year, the EPFO's apex decision making body, the Central Board of Trustees (CBT), had suggested exploring possibility of giving such options. Labour Minister Santosh Gangwar who is also Chairman of the CBT told PTI, "By introducing numerous digital tools, the service levels for workers as well as employers have been eased a lot." "By way of supplementing the employer's share of contribution at the rate of 12 per cent, a good number of approximately 90 lakh new employees are extended the benefit of social security net through the EPFO," he said.

Under Pradhan Mantri Rojgar Protsahan Yojana (PMRPY), the Government of India is now paying full employer's contribution (EPF and EPS both) with effect from April 1, 2018 for a period of three years to the new employees as well as to the existing beneficiaries for their remaining period of three years. In 2018, a pensioners' portal was also launched through which all EPFO pensioners can get details of pension-related information. The EPFO presently covers 190 industries (mentioned in the schedule 1 of

the EPF Act) with over 20 crore accounts in over 11.3 lakh covered establishments. For the EPFO's 63.2 lakh pensioners, 55.3 lakh Jeevan Praman have been received as on October 29, 2018 and 49.4 lakh have been approved.

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Source

No proposal to replace NPS with old pension scheme – The Economic Times – 31st December 2018

The number of family pensioners getting pension through Central Pension Accounting Office by authorised bank under the NPS as on November 30 was 4,779.

The government has no proposal to replace the National Pension Scheme (NPS) with the old pension scheme due to rising and unsustainable pension bill and competing claims on the economy, Parliament was informed on Monday.

"There is no proposal to replace the National Pension Scheme with old pension scheme in respect of Central Government employees recruited on or after January 1, 2004," Minister of State for Finance Shiv Pratap Shukla said in a written reply in the Lok Sabha.

The Minister, in his reply to Shimla MP Virender Kahsyap, said the pension bill had been rising and had become unsustainable. A total of Rs 1, 56,641.29 crore was spent paying pension during 2017-18.

Shukla said that the mandatory contribution by the central government for Tier 1 accounts of its employees covered under NPS had been enhanced from the existing 10 to 14 per cent, which will entail an additional financial impact of Rs 2,840 crore in 2019-20.

The number of family pensioners getting pension through Central Pension Accounting Office by authorised bank under the NPS as on November 30 was 4,779, he added.

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