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QUOTE OF THE WEEK

"The quality of a leader is reflected in the standards they set for themselves".
- Ray Kroc

INSIDE THE ISSUE

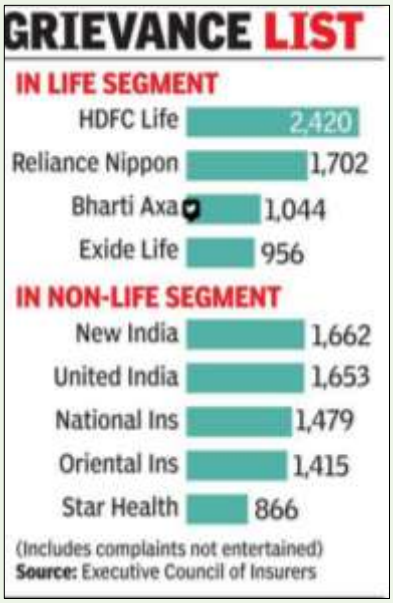
LIFE INSURANCE

Most life insurance plaints pertain to mis-selling – The Times of India – 14th November 2018

A bulk of the complaints received by the insurance ombudsman in the life sector is in respect of mis-selling of policies by intermediaries. In non-life, however, rejections of health claims on grounds of a pre-existing ailment are the primary cause of dispute.

According to the annual report of the Executive Council of Insurers (ECOI), which facilitates the institution of Insurance Ombudsman in India, mis-selling is done by forging the proposer's signature on forms or by selling long-term plans even though the proposer does not have the capacity to maintain the policy beyond the initial payment.

While the regulator IRDAI has made it mandatory for insurers to follow up with verification calls, the report states that the intermediaries (brokers and agents) have been tutoring customers to accept all terms when verification calls are received.



According to secretary general M.M.L Verma, on an all-India basis, the complaints are almost equally divided between life insurance and non-life insurance.

However, complaints within non-life insurance were overwhelmingly in respect of health insurance.

"After the amendment to the rules last year, the ombudsman can pass orders against insurance companies as well as intermediaries.

This means that we can issue an order again banks, but we hold the insurance company responsible because the agents are representatives of the company," said Milind Kharat, insurance ombudsman, Mumbai and Goa.

According to Kharat, the ombudsman office is a very effective forum for redressing customer complaints as there are no fees and no requirement of a lawyer and customers can register their complaint via email.

He said that the awards for mis-selling were limited to refund of premium as the ombudsman did not have the power to impose penalties.

The other limitation is that the maximum award that an Ombudsman can issue is for Rs 30 lakh.

"We have recommended that since the office looks at only individual complaints there should not be any limit considering that many individuals are taking Rs 1 crore cover for term or health insurance.

Besides pre-existing claims, one of the common cases of complaints in health insurance is the insurer's rejection on the grounds that the expenditure did not fall within 'reasonable and customary charges".

"Reasonable is a very subjective term and what is reasonable in one part of the country may not be reasonable in another," said Kharat.

In many cases insurers reject claims for expensive lenses in cataract operations. "Inadmissibility of cost of multi-focal lens in case of cataract treatment should be clearly spelt out in the policy terms if the same is excluded," the report said.

TOP

Source

GENERAL INSURANCE

What to consider while buying a cyber insurance plan - The Economic Times – 15th November 2018

Cyber fraud is on the rise and it has become all the more important to insure ourselves and our hard-earned money from scamsters. Most of us use personal email and carry out financial transactions not just from our personal computers and smartphones but even from office computers and public Wi-Fi. Accessing personal information from different devices exposes us to all types of risks.

A cyber insurance policy will protect us from online breaches on all gadgets that are connected to the Internet. In India, there are two such cyber insurance plans from general insurance companies - Bajaj Allianz's Individual Cyber Safe Insurance Policy and Cyber Security by HDFC ERGO.

While getting such a policy there are three important things to consider. One, what all events are covered in the plan.Second, the sub-limits.And three, which clauses represent the claim against any financial loss.

What is covered?
Look closely at the inclusions, i.e., what all is covered in the policy. Some plans will treat the inclusions as 'clauses' while others may call them the 'limit of liability'. An important element of cyber security is malware and some plans may provide it as an optional cover.

"It is important to have protection from malware threats in the form of antivirus and firewalls in place however; there can still be an attack on to the system due to a malware. Maintaining download discipline from legitimate sources would minimise malware threats," says SasikumarAdidamu, Chief Technical Officer, Bajaj Allianz General Insurance.

A typical cyber insurance plan should cover the following. So, while choosing between the two cyber insurance policies that are available, see if these aspects are covered:

- A financial loss resulting from being a victim of email spoofing and phishing
- Fraudulent online transactions in one's bank account, debit or credit card or e-wallet
- Reputational liability, including claims alleging defamation and invasion of privacy
- Losses and expenses related to defense and prosecution cost related to identity theft
- Restoration cost to retrieve data or computer program damaged by entry of the malware
- Expenses incurred on counselling services treatment
- Claim for damages against third-party for privacy breach and data breach
- Cyber extortion loss and transportation for attending Court summons

Sub-limits
In Bajaj Allianz Individual Cyber Safe Insurance Policy there are 10 clauses, and each one has a sub-limit. For example, the claim for e-mail spoofing, phishing and social media cover will be restricted to 15 percent, 25 percent and 10 percent respectively and so on. In addition, the insurer pays for IT Consultant Services Cover cost, which is a fixed amount as per the amount of plan opted for.

Similarly, in Cyber Security by HDFC ERGO, there are sub-limits but protection from malware attacks has been kept optional, and thus will cost extra. This plan also offers a Family Cover for coverage of Rs 5 lakh and above.

Clauses for financial loss
Generally, only two events, i.e., phishing and e-mail spoofing covers the financial loss. Also important to note is that if any event gives rise to a claim, one may then claim under only one of the insuring clauses per event. "In case of multiple breaches at the same time, it is up to the customer to choose one breach for which he or she decides to file the claim. At one point of time, claim for only one breach can be filed. However, there is no cap on the number of claims that can be filed in a given policy period," informs Adidamu.

How the policies work

For example, if one buys Rs 5 lakh plan, the annual premium of Bajaj Allianz Individual Cyber Safe Insurance Policy is Rs 1,823 (exclusive of GST). The percentage of limit of liability will differ as per the breach, i.e., a financial loss due to phishing has a 25 percent limit while email spoofing has a 15 percent limit. So, for phishing the claim will be capped at Rs 1.25 lakh and any claim resulting from email spoofing will be restricted at Rs 75,000, despite buying the plan for Rs 5 lakh.

What you should do

As a user, even if there is cyber insurance, take adequate precaution. The circumstances leading up to the cyber attack can be closely looked into. "This is a subjective situation that may vary from claim to claim, it will depend on various factors such as how has the cyber attack happened and what were the circumstances under which a loss has triggered? We as an insurer would not want to refrain from accepting the claims that are honest and genuine," says Adidamu.

Source

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Taking a trip abroad? Pack in your travel insurance – Mint – 15th November 2018

September to January is a busy period for international travel: students join their overseas colleges often accompanied by parents; grandparents visit their children in the winter break; and the well-heeled set out on vacation. Most international travellers buy overseas travel insurance because the cost of medical treatment abroad is prohibitive. Cardiac surgery in the US will cost about $100,000, for example. The Schengen countries insist on insurance as a pre-condition for their visa.

In the past few months I have received several claim intimations from international travellers. Unfortunately, all those claims have been rejected, for the right reasons. This set me thinking that most buyers do not fully understand their travel insurance. These are the questions I get asked most often.

Will I be insured for an existing health condition? Most insurers do not cover hospitalisation related to existing health issues. For example, if you suffer from hypertension, cardiac claims are unlikely to be paid. A few insurers now provide limited cover for emergency treatment, even if related to existing conditions. The sum insured is restricted to about $10,000 in such cases.

However, you must declare the existing ailment when you buy the insurance. Non-disclosure is the single largest reason for rejecting claims. Claims will be rejected even if they are not related to the un-disclosed disease.

If I fall ill, will the payment be cashless? If hospitalised, the process can be cashless which means that the hospital will be paid directly by the insurer. Inform the insurer the moment you can so they can initiate the process. Insurers have international assistance partners that manage these claims. If there is a doubt about the claim's acceptability, for example a pre-existing condition that was not disclosed, then the insurer will have you go for reimbursement where you pay the bill and claim later. Outpatient claims are also covered by travel insurance and are mostly reimbursed after adjusting for a deductible of about $ 100.

Can a senior citizen buy overseas travel insurance? Seniors are a significant proportion of overseas travellers but have the hardest time buying travel insurance. Up until the age 70, travel insurance can be easily bought. Between 70 and 80, the number of options shrinks but it is still possible to buy. After that most insurers will turn you down. Some insurers can sell even after 80 but need internal underwriting approvals and will have you undergo medical tests. As you grow older, insurers reduce the maximum sum insured that you can buy. For most countries, with the notable exception of the US, the reduced sum insured is sufficient. If a senior finds it difficult to buy insurance locally, they also have the option of purchasing this in the country they visit. That is relatively expensive though.

Is it better to buy travel insurance in India or overseas? Travel insurance bought here is more economical than and just as effective as international travel insurance. A 50-year-old travelling to the US for a fortnight will pay about Rs 3,500 for a cover of $0.5 million. This will cost twice as much if bought

overseas. It is also easier to follow up with insurers locally. Overseas insurance is better when you have serious pre-existing conditions that are not insurable in India.

Can I get paid if my flight is delayed or cancelled? Insurers pay these claims if delays are caused by specific, pre-identified reasons. These could range from acts of god such as earthquakes, floods and inclement weather to fires, strikes and equipment failure. Delays or cancellations for other reasons will not be paid.

What if my baggage is lost or delayed? If your entire bag is lost you will be paid a specified amount. This will not cover jewellery. If just a few items from your bag are missing that will not be paid for. In cases of delay, you will be reimbursed the cost of personal effects to manage until your bag arrives.

Can I buy insurance after leaving the country? The insurance must be bought while in India. This prevents people from buying insurance when they know they have to visit a hospital. Insurers will make an exception if you have a credible reason but it will take a lot of follow-up.

To summarise, you must buy travel insurance when going overseas. Its main benefit kicks in if you meet with an accident or suffer a medical emergency. The insurance is less useful for routine health issues or travel-related inconveniences.

TOP

Source

Govt invites bids from i-bankers for selling stakes in NIACL, GIC – Mint – 15th November 2018

The Union finance ministry has sought proposals for appointing merchant bankers and selling brokers for the disinvestment of its stakes in General Insurance Corporation of India (GIC) and the New India Assurance Company Ltd (NIACL) using the stock exchange platform.

"The government is considering for disinvestment a part of its paid-up equity in GIC and NIACL out of its shareholding through "offer of sale (OFS) by promoters through stock exchanges. Proposals are invited by 1530 hours (IST) on 7 December 2018 from reputed merchant bankers either singly or as a consortium, with experience and expertise in public offerings in the capital market, to act as merchant bankers and to assist and advise government in the process," the Department of Investment and Public Asset Management (DIPAM) said in newspaper advertisements published on Thursday.

The cabinet committee on economic affairs (CCEA) in January 2017 approved the public listing of five state-owned non-life insurance companies and reducing the government's stakes in them to 75% from 100%.

Out of Oriental Insurance Company, National Insurance Company, NIACL, United India Insurance and national reinsurer General Insurance Corporation of India, or GIC Re, the government last year listed GIC and NIACL through initial public offerings, selling 12.5% and 11.65% of its stakes respectively in the equity market.

Stake sales in these two insurance companies fetched the government a total of Rs17,357 crore. The government is likely to sell another 10% in GIC and NIACL to meet the minimum public shareholding norm of the equity market regulator SEBI for all listed companies.

The government has so far garnered Rs15,247 crore through disinvestment in the current fiscal year against the target of Rs80,000 crore.

With its unsuccessful bid to privatize Air India, the government may find it difficult to achieve the target unlike last year.

In 2017-18, the government overshot its disinvestment target of ₹72,500 crore by garnering ₹1 trillion, aided by completion of the acquisition of Hindustan Petroleum Corp. Ltd (HPCL) by Oil and Natural Gas Corp. Ltd (ONGC) for around ₹37,000 crore.

Since achieving the disinvestment target is key to meeting its fiscal deficit target of 3.3% of gross domestic product (GDP) in 2018-19, the government may ask public sector undertakings (PSUs) to buy back their own shares, thus transferring surplus cash to the government.

In 2017-18, the Union government carried out as many as 13 buybacks in cash-rich PSUs to meet its disinvestment target.

TOP

Source

GIC Re Q2 profit falls 64% on underwriting losses - The Hindu Business Line – 13th November 2018

State-owned re-insurer General Insurance Corporation of India (GIC Re) posted a sharp 63.8 per cent drop in its net profit to Rs513.84 crore for the second quarter of the fiscal due to higher underwriting losses.

Its net profit stood at Rs 1,419.11 crore as on September 30, 2017, and it had also reported a 98 per cent rise in net profit for the first quarter of the fiscal at Rs771.42 crore.

GIC Re has also reported a near 29 per cent drop in net profit to Rs 1,285.27 crore for the first half of the financial year 2018-19 as against a net profit of Rs1,809.22 crore a year ago.

The re-insurer's underwriting losses amounted to Rs 2,264.88 crore for the July-September quarter of this fiscal, as compared with a profit of Rs703.74 crore in the same quarter a year ago.

Its underwriting losses saw a sharp increase across almost all segments including motor, aviation, engineering, health and marine cargo.

However, its gross premiums written rose 15.5 per cent to Rs8,325.95 crore for the quarter ended September 30, as against Rs7,209.61 crore for the same period of 2017-18.

Total income rises

During the reporting quarter, its total income rose to Rs12,879.90 crore from Rs10,714.69 crore a year ago. "Other income includes forex gain of Rs164.87 crore for the half year ended September 30, 2018," GIC said.

It had a solvency ratio of 1.73 at the end of the reporting quarter, which is in line with 1.72 a year ago. It is also well above the minimum required solvency ratio of 1.5 times.

The re-insurer's shares fell 1.55 per cent and closed at Rs320.20 apiece on the BSE.

TOP

Source

Cyber fraudsters eye govt officials and professionals – The Times of India – 12th November 2018

A sharp spike has been noticed in the number of cybercrime cases registered this year and mostly professionals and government servants have been targeted by the conmen. Thesleuths of cyber cell said that a gang operating from national capital region gained access to financial data through banks, insurance agencies and courier agencies and targeted victims in Lucknow.

Till October this year, 1,900 cases of cyber fraud were reported in which 1,026 professionals were targeted.

In comparison, total 1,725 cases were lodged in 2017, and only 417 victims were professionals. In 2017, housewives constituted the highest number of victims — 828 —, while this year only 374 have lodged complaints so far. Cyber cell officials said that one gang based in NCR, and another from Jharkhand and Bihar have been found involved in cyber fraud cases lodged in the city. The officials further said that they have cracked over 70 % cases this year.

Officials also said that after demonetization, there has been an increase in use of digital transactions and more people have started using them but people lacking in awareness fall prey to cyber criminals.

Cyber cell nodal in charge Abhay Mishra said that the victim shared OTP after revealing credit, debit card details and were duped.

“This year, since January 5, a reverse trend has been seen. Professionals have been targeted the most followed by retired persons and then housewives,” said Mishra. In most cases, the accused arrested were contractual employees of banks, insurance agencies or courier agents.

They used to steal card data and noted the phone number of customers during delivery of cards, Mishra added. The contractualemployees work in connivance with bank employees. Mishra cautioned people to not to respond to calls and mails seeking bank and card details as banks never ask for such details on phone or email.

TOP

Source

Insurance firms can't be liable to pay compensation to those who travel in goods carriers: Madras HC - The Economic Times – 9th November 2018

The Madras High Court Friday held that insurance companies cannot be made liable to pay compensation to accident victims who travel in goods carriers.

Justices K. K .Sasidharan and R Subramanian said that in the light of the categorical pronouncements of the Supreme Court in various accidents, Motor Accidents Claims Tribunals are not right in directing insurance companies to pay the compensation and recover the same from the vehicle owner.

The bench gave the ruling while passing orders on a batch of appeals from Bharati AXA General Insurance Company Limited in Bengaluru, challenging a September 23, 2014 order of the Motor Accidents Claims Tribunal in Dharmapuri, on October 24.

On September 1 2011, a 16-member marriage party from Kottapatty village had engaged a goods carrier to go to Soolakurichi to attend the event. On the way back, the van turned turtle, killing some people and injuring others.

They moved the tribunal, which in September 2014 awarded various amounts.

The tribunal directed the insurance firm to pay the amount and recover it later from the vehicle owner.

Aggrieved, the insurance company moved the court.

The court said it was no doubt true that in many cases, the claimants may not be able to realise the award amount from the owners of the vehicles involved in the accident.

"But the said factual situation alone cannot impel us to do something against the provisions of the statute and the decisions of the larger benches of the Supreme Court," the bench added.

TOP

Source

India: Motor accidents kill 405 people each day – Asia Insurance Review

A total of 464,910 road accidents were reported in India last year, claiming 147,913 lives and causing injuries to 470,975 persons, according to statistics for road accidents, injuries and fatalities released by the Indian government.

The figures translate into 405 deaths and 1,290 injury cases each day from 1,274 accidents, reports *Autocar India* citing the government data.

Nevertheless, the number of road accidents declined from the peak of 501,423 in 2015 to 480,652 in 2016 and further to 464,910 in 2017.

The government report further states that there has also been a decline in the number of fatal accidents (accident involving at least one death).

There were 134,796 fatal accidents reported in 2017, a dip of 0.9%. On the other hand, the road accident severity (measured by the number of persons killed per 100 accidents) saw a marginal increase in 2017 over the previous year.

Tamil Nadu records highest number of accidents

The report reveals that Tamil Nadu recorded the highest number of road accidents in 2017, but the number of people killed in road accidents was the highest in the northern state of Uttar Pradesh.

Over speeding topped the list of factors behind road accidents, and caused 70.4% of all motor accidents, 66.7% of lives lost and 72.8% of individuals injured.

TOP

Source

HEALTH INSURANCE

Now, free treatment of up to Rs 5 lakh per year for BPL families – The Times of India – 16th November 2018

Ending three months of confusion, the government has merged its Arogya Karnataka scheme with the Centre's Ayushman Bharat plan to roll out a comprehensive health insurance scheme for the people of the state. The schemewill cover an estimated 4.4 crore people.

"We signed an MoU with the Union government on October 30 and the scheme has been in force since then," water resources minister DK Shivakumar said on Thursday.

Under the scheme, which will continue to be called Ayushman Bharat and Arogya Karnataka, a BPL (below poverty line) family can avail treatment up to Rs 5 lakh per annum, and an APL family up to Rs 1.5 lakh.

"We've listed 1,614 procedures in 385 government and 531 private hospitals across the state which will be covered by the scheme," Shivakumar said. "BPL families must produce Aadhaar and ration cards, while for APL families only Aadhaar will do."

To help people in border districts get treatment in neighboring states, the government has entered into an agreement with 36 hospitals in border cities and towns of Kerala, Maharashtra, Telangana and Tamil Nadu. "Those who have migrated to Karnataka can also receive benefits of the scheme," Shivakumar said.

While urging people to procure health cards from Bengaluru One, Karnataka One and other designated centres, the minister clarified: "People who do not have health cards can also avail treatment.''

The government has classified health procedures under three categories: 2A (simple and secondary treatment, mostly at the government hospitals), 2B (minor emergencies to be treated at private hospitals if government ones are not equipped for such procedures) and 3(tertiary care to be treated at empanelled private hospitals).

It has also categorized 169 medical procedures as emergencies for which patients can be taken either to a government or a private hospital.

"To create awareness, we will conduct a workshop for representatives of government hospitals on November 20 and for private hospitals on November 27," Shivakumar said.

TOP

Source

Health Insurance may become more consumer friendly: IRDAI panel calls for removing these exclusions – Financial Express – 12th November 2018

In order to make health insurance more customer friendly, a working group set up by the insurance regulator has recommended that diseases such as Alzheimer's, Parkinson's, AIDs/HIV acquired after the policy inception should not be be excluded. It has recommended that there should not be any permanent exclusion in the policy wordings for any specific disease, whether it is degenerative, physiological or chronic in nature.

The Insurance Regulatory and Development Authority of India (Irdai)'s working group report for standardisation of exclusions in health insurance contracts has recommended that waiting periods for any specific disease can be a maximum of four years. However, waiting periods for conditions such as hypertension, diabetes, cardiac cannot be for more than 30 days.

The panel had initially recommended a list of 17 conditions for which insurers can incorporate permanent exclusions if they are pre-existing at the time of underwriting. It also suggested that a standard format of consent letter to be given by the proposer may be specified. Sub-limits or annual policy limits for specific diseases in terms of amount, percentage of sum insured and number of days of hospitalisation will be part of the policy design.

Non-disclosed conditions

Non-declaration or misrepresentation of material facts is a major concern in health insurance. The working group has recommended that after eight years of continuous renewals, claims cannot be questioned based on non-disclosure or misrepresentations when taking policy. The policy will be incontestable in terms of application of any exclusions except for proven fraud as well as permanent exclusions specified in a policy contract.

Standardisation of exclusions

The panel has recommended that exclusions because of alcohol or substance abuse must be reviewed and standardised. This exclusion will be modified to exclude only treatments for alcoholism and drugs or substance abuse unless associated with mental illness.

It has also recommended formation of Health Technology Assessment Committee, which will examine and recommend inclusion of advancements in medical technology as well as new treatments/ drugs for coverage under insurance.

It has also recommended that "no exclusions" should be permitted for any advancement in technology or advance treatments if these are in the list approved by this committee. However, insurers can either incorporate co-payments for such treatments or subject them to the usual, customary and reasonable clause. Insurers cannot deny coverage for claims of oral chemo therapy and peritoneal dialysis.

The panel suggested that insurers start adopting an Explanation of Benefits in their prospectus and policy schedule which would be understood by customers.

The panel has also said that new treatments such as balloon sinuplasty, deep brain stimulation, oral chemotherapy, immunotherapy, robotic surgeries, and stem cell therapy may be included in health covers.

In case of migration to another policy because of product withdrawal, the policyholder will be given credit to the accrued gains of pre-existing diseases waiting period to the extent that is permitted either in the porting out product or porting in product, whichever is less.

In order to make the pricing structure transparent, the panel has suggested that every insurer publish the list of items which will not be billed separately and make it available to the insured either in the policy contract or as a link on the website.

TOP

Source

Inclusive health policies: Pricing should be updated to cover patients under all types of scenarios - Financial Express – 10th November 2018

Until August of this year, health insurance policies did not cover mental illnesses. But then, the Insurance Regulatory and Development Authority of India (Irdai) asked insurance companies to make provisions to cover mental illness, in a circular dated 16 August. The circular was a step in the right direction as it increases the scope of health insurance coverage for a large section of the population.

As per the National Mental Health Survey of India for FY16 conducted by the National Institute of Mental Health and Neuro Sciences, nearly 15% of Indian adults are in need of active intervention for one or more mental health issues and the WHO estimated 56 million people suffer from depression and 38 million from anxiety disorders in a report released earlier this year. According to the circular every insurer needs to make provisions for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness and stated that insurers will need to comply with these provisions with immediate effect.

However, the circular only states that there should be no discrimination between the two illnesses, mental and physical. That doesn't change anything for the insurers in terms of their underwriting decisions. Even now, the insurer can altogether deny health insurance to a person suffering from a physical illness, say cancer or heart disease, as per its underwriting norms. The same underwriting criteria would then have to apply to individuals with a pre-existing mental illness.

To this effect, according to recommendations of a panel set up by Irdai, a list of 17 diseases, including chronic kidney disease, Hepatitis B, Alzheimer's, epilepsy and HIV and AIDS, would be excludable from health insurance polices, but only if they are pre-existing. Although the present situation is better than a complete ban on coverage of mental health illnesses, in order to ensure adequate health insurance coverage, insurers should be able to price policies and premiums appropriately enough to enable them to cover all types of scenarios and situations when it comes to the health of individuals. Only then will the penetration of health insurance increase.

TOP

Source

In Delhi, private hospitals may offer Modicare - The Economic Times – 10th November 2018

In a move to ensure advanced super specialty care for beneficiaries of Ayushman Bharat, the Centre plans to directly empanel Delhi-based private hospitals which have so far been out of the purview of the scheme as Delhi government has not signed onto the initiative.

The National Health Agency (NHA) – responsible for implementation of the Pradhan Mantri Jan ArogyaYojana – is in the process of empanelling private hospitals, including big corporate chains offering super-specialty care. But the deal will benefit patients from neighboring states seeking advanced medical care but not Delhi residents.

"We are in talks with these hospitals, including Apollo and Max. They are willing to participate in the scheme but since the Delhi government is not on board, these hospitals are losing out on business which they can get through the scheme. We also need these hospitals to have a strong pool for patients. So, we are working out a mechanism to have them on board," a senior official told TOI.

However, only beneficiaries from other states will be able to seek hospitalisation in Delhi's hospitals under PMJAY with their respective states footing the bills, Delhiites themselves will be deprived of the benefits under the scheme.

This is significant because many patients from Uttar Pradesh, Rajasthan, Haryana, Bihar and Madhya Pradesh come to Delhi seeking hospitalisation for speciality care with major public as well as private hospitals having advanced tertiary care facilities here.

According to the Association of Healthcare Providers (India), private sector alone has over 1,000 hospitals in Delhi, of which nearly 140 are over 100-bedded facilities including corporate hospitals. The total capacity under the private sector in Delhi is estimated to be around 30,000 beds. Out of this 30% are under-utilised or remain vacant.

Apart from this, central government hospitals like All India Institute of Medical Sciences, Safdurjung Hospital, Ram Manohar Lohia Hospital and Lady Hardinge Hospital have over 9,000 beds. Delhi government itself has 39 hospitals accounting for 11,000 beds.

"The government needs more and more super speciality care hospitals to make Ayushman Bharat a success and only hospitals with more than 100 beds can provide such advanced treatment and care.

Therefore, Delhi plays a very important role because patients from across the country come here to seek tertiary care," says AHPI director general Girdhar Gyani.

PMJAY, dubbed as Modicare, aims to cover nearly 50 crore beneficiaries from 10.74 crore deprived families with an annual cashless health cover of Rs 5 lakh per family.

PMJAY is the secondary and tertiary care arm of the government's flagship Ayushman Bharat scheme, which also includes plans to open health and wellness centres across the country to cater to people's primary healthcare needs.

Discussions between the Centre and Delhi government are stuck over differences on the scheme's name. Delhi government wants the scheme to be called 'Mukhya MantriAamAadmiSwasthyaBimaYojana Ayushman Bharat' for implementation in Delhi.

TOP

Source

CROP INSURANCE

Crop insurance under a cloud - The Tribune – 16th November 2018

Insurance firms, both in the public and private sectors, have reportedly made a killing by offering crop insurance to farmers in about two dozen states. The Tribune reported abnormal gains by a dozen insurance firms through the Pradhan Mantri Fasal BimaYojna (PMFBY).

Insurers reportedly received a gross premium of Rs 22,362 crore under the scheme in 2016-17 and saved huge sums even after they settled 3.01 crore claims worth Rs 15,902 crore.

This margin reportedly jumped to Rs 9,335 crore in the successive period, apparently due to a sharp decline in the number of claims to 1.26 crore.

Insurance is a high-risk business and it is normal for firms to have huge margins in an event-free year. But, the non-payment of legitimate claims could also be a reason for unprecedented margins. A fair probe in this matter is, therefore, necessary.

Private insurers overwhelmingly participated in the PMFBY because of the government's open-arm invitation. Naturally, they saw immense 'profit' opportunity, the sole guiding principle of any private venture.

They cannot be criticised for making money, but profiteering from a social scheme is unacceptable. A thorough audit is a must to ascertain that the profit is legitimate.

The scheme per se is well intentioned. It promises to secure lives of Indian farmers and protect them from the vagaries of nature. Hopefully the government, mainly in states, takes adequate administrative measures to ensure quick disbursal of insured sums to aggrieved farmers as private insurers do not have any incentive to pay the farmers for their damaged crops.

Risk assessment is up to the states, for instance, Punjab does not foresee any major failure of paddy and wheat crops in the manner covered under the scheme. Hence it declined to waste public money on unnecessary premium.

The scheme involves huge public money and, therefore, the Comptroller and Auditor General (CAG) of India need to conduct a performance audit to rationalise the premium amount. The projected margins indicate that there could be scope to further reduce the premium burden on the farmer by coaxing insurers against profiteering from a public scheme.

TOP

Source

Farmers' coverage stagnant but premiums up 350% under PM's flagship scheme - Business Standard – 13th November 2018

In January 2016, Prime Minister Narendra Modi launched a revamped crop insurance scheme, his government's flagship scheme for farmers, the Pradhan Mantri Fasal Bima Yojana(PMFBY).

It would "bring about a major transformation in the lives of farmers", Modi had said at the time.

However, after the implementation of the PMFBY, the number of farmers covered by crop insurance has gone up only by 0.42%. On the other hand, premiums paid to insurance companies have increased by 350%, according to data that the Ministry of Agriculture and Farmer's Welfare provided to *The Wire* under a Right to Information (RTI) application.

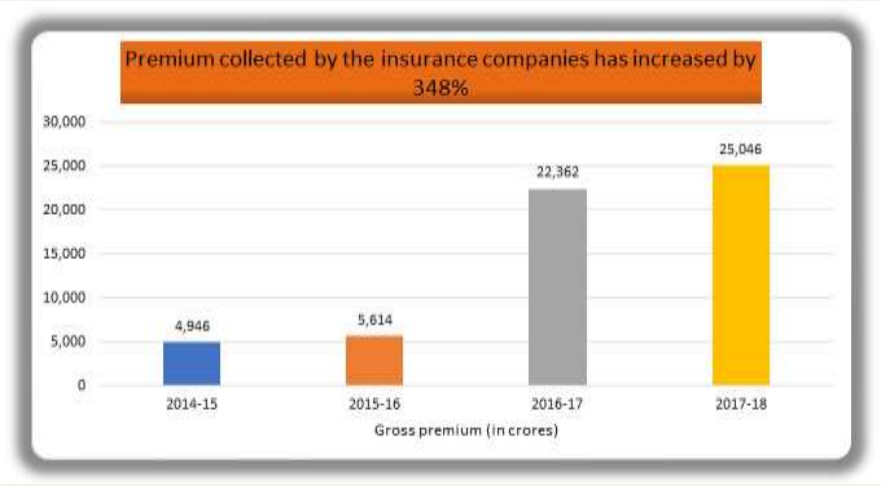
When the government announced the new scheme, it said that the PMFBY "incorporates the best features of all previous schemes and at the same time, all previous shortcomings/weaknesses have been removed".

It claimed that farmers will have to pay lower amounts as premium and that through the use of technology, the government will ensure 'quicker settlement of claims' compared to the previous crop insurance schemes.

Government claims not borne out by data

For the two seasons that the PMFBY has been implemented (2016-17 and 2017-18), insurance companies – private and public – collected a gross premium of Rs 474.08 billion. Total claims paid as on October 10, 2018 was Rs 316.13 billion.

For 2014-15 and 2015-16, when the National Agricultural Insurance Scheme (NAIS) and Modified National Agricultural Insurance Scheme (MNAIS) were operational before getting subsumed under the PMFBY, the gross premium collected was Rs 105.60 billion. And total claims paid, at Rs 285.64 billion was in fact more than the premium collected.



Source: RTI response of the Ministry of Agriculture and Farmer's welfare dated October 10.

Farmers express no confidence, but premiums continue to increase

So, under the PMFBY, gross premium collected increased by Rs 368.48 billion or 348%, but the coverage has remained pretty much stagnant.

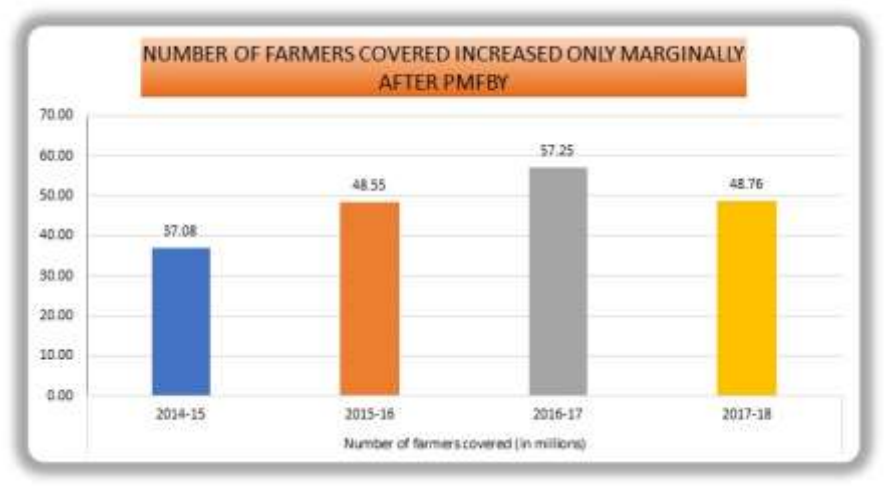
In 2015-16, before the launch of the PMFBY, 48.55 million farmers in India were enrolled in the existing crop insurance schemes. By the end of 2017-18, two years into the PMFBY and despite insurance companies having collected Rs 474.08 billion as premium, the number of farmers covered by crop insurance has increased by only two lakh, or 0.42%.

In fact, during the first year (2016-17) of the PMFBY, the total number of farmers covered increased to 57 million. But in the next year (2017-18), the number fell to 48 million, a drop of 14%.

Signaling that farmer' initial expectations regarding the benefits of the scheme were not met, a large proportion – of those who could, since enrolment in PMFBY is compulsory for farmers who take crop loans – opted out.

Similarly, the total crop area insured has increased from 46.39 million hectare to only 49.04 million hectares after the implementation of the PMFBY. And as in the case of number of farmers insured, the coverage area also declined between 2016-17 and 2017-18.

Compare this with the target that the Modi government had set for itself – bringing 100 million hectares under PMFBY by 2018-19. The target remains as far as it was when the scheme was initiated.



Source; RTI-obtained documents.

Responding to a question in the Rajya Sabha in August, the minister of agriculture and farmer's welfare admitted that there had been a decline in coverage. He stated that "announcement of Debt Waiver Scheme in Maharashtra and Uttar Pradesh, farmer's perception of mitigated risk in 2017-18, which was a good monsoon year, reduplication due to Aadhaar being made mandatory for coverage etc." were the reasons.

Despite the fall in the number of farmers insured and coverage area, the total premium collected by insurance companies has not fallen. It has actually increased. In 2016-17, the total premium collected was Rs 223.62 billion. This went up to Rs 250.46 billion in 2017-18.

The average premium per farmer went up by 31% to Rs 5,135 in 2017-18.

According to Siraj Hussain, former agriculture secretary and now a senior fellow at the think tank ICREAR, more detailed analysis of data at the state level is required to pinpoint why premiums have increased. "We have to look at data and analyse the state and the crops where the premiums have increased. But, in principle, if you add more conditions e.g. cover for crop damage due to stray animals and penalties proposed in PMFBY modified guidelines 2018, the companies are likely to take such factors into account while quoting the premium rates," he told *The Wire*.

Claims paid increase marginally, but delays are a major cause for concern

In the two years that PMFBY has been in place, total claims paid to farmers have increased only marginally, despite the total premium having increased by more than 4.5 times.

For the two years before PMFBY, farmers were paid total claims worth Rs 285.64 billion. For the two years after PMFBY, the data provided by the ministry shows that total claims paid have only increased by 10% to Rs 316.13 billion as of October 10, 2018. Thus, the surplus for insurance companies till that date is Rs 157.95 billion, almost a third of the premiums collected.

However, it is important to note, the ministry points out, that "a majority of claims for rabi 2017-18 are yet to be estimated/approved by company". The ministry added that in the data provided, 99% of the amounts reflected as claims paid for 2017-18 are for kharif 2017 and only 1% reflect claims paid for rabi 2017-18.

The RTI response, on which our analysis is based, is dated October 10, over four months after the rabi harvest ended in May. According to the PMFBY guidelines, claims should be settled within two months of harvest. Recently, the government also announced that it would impose a 12% penalty on insurance companies which delay payments.

Despite this, the Ministry of Agriculture and Farmer's Welfare, as of October 10 2018, could not even provide the figure for estimated claims for the 2017-18 Rabi season. One of the key complaints of farmers with the PMFBY, as *The Wire* has reported earlier, has been that their claims are not settled in time.

Farmers argue that if their crop suffers damage in one of the sowing seasons, it means that they have not earned any surplus for that particular season. Consequently, they are short of cash to sow for the next season. Crop insurance can be useful if the claims are paid to farmers before sowing for the next season begins.

"See, if the rabi crop is damaged then claims need to be paid before the kharif sowing takes place. Otherwise how will the farmer sow?" said Vikal Pachar, who has been leading farmers in Bhiwani and Sirsa in their struggle against ICICI Lombard since February this year for settlement of their claims pertaining to kharif 2017.

List of empanelled insurance companies under PMFBY

Public Insurance Companies

Agriculture Insurance Company of India Ltd
United India Insurance Company Ltd
National Insurance Company Ltd
Oriental Insurance Company Ltd
New India Assurance Company Ltd

Private Insurance Companies

ICICI-Lombard General Insurance Company Ltd
IFFCO-Tokio General Insurance Company Ltd
Cholamandalam MS General Insurance Company Ltd
Tata-AIG General Insurance Company Ltd
Future Generali India Insurance Company Ltd
Reliance General Insurance Company Ltd
Universal Sompo General Insurance Company Ltd
SBI General Insurance Company Ltd
Bajaj Allianz General Insurance Company Ltd
Shriram General Insurance Company Ltd
Bharti-AXA General Insurance Company Ltd
Royal Sundaram General Insurance Company Ltd.

Source: RTI response of the Ministry of Agriculture and Farmer's welfare dated October 10

Source

Insurance companies made 'super normal profits'

A recent performance evaluation of the PMFBY by the Indian Institute of Management (Ahmedabad) concluded that the financial management of the scheme needs to be tweaked to "ensure companies do not make super-normal profits".

The report, supported by the Ministry of Agriculture and Farmer's Welfare, also noted that "too many insurers (18 in 2017-18) have been empanelled".

"Many of them do not have adequate experience and infrastructure and intent of servicing public good," it said. The report also added that in the future it would be "advisable" to restrict the number of empanelled insurance companies to just ten for "better monitoring and administration".

TOP

Firms earned Rs 15,795 crore in 2 years of FasalBimaYojana - The Tribune – 13th November 2018

Insurance companies across the country earned a whopping Rs 15,795 crore as profit in two years from the Pradhan Mantri Fasal Bima Yojana (PMFBY), according to a reply received under the Right to Information Act.

While the farmers' wait for increase in income continues the profit of insurance firms increased by one-and-a-half times in just one year of the introduction of the PMFBY.

The insurance firms posted a profit of Rs 9,335.62 crore in 2017-18 — a robust growth of 44.52% compared to the previous year's (2016-17) profit of Rs 6,459.64 crore in the country.

Information received from the Union agriculture ministry by RTI activist PP Kapoor revealed that 11 insurance firms, including government-owned Agriculture Insurance Company of India (AIC), earned a total of Rs 15,795.26 crore in the first two years of PMFBY.

The RTI reply disclosed that the insurance firms got a gross premium of Rs 22,362.11 crore and paid an insurance claim of Rs 15,902.47 crore to 3,01,26,403 farmers in 2016-17.

Similarly, these firms disbursed claims of Rs 15,710.25 crore against a premium of Rs 25,045.87 crore to 1,26,01,048 farmers. The RTI reply, however, added that about Rs 512 crore approved insurance claims are yet to be paid, while majority of Rabi crop claims are yet to be estimated/approved.

Kapoor, who analysed the data, said the insurance firms earned to the tune of Rs 530.30 crore per month in 2016-17, which rose to approximately Rs 778 crore per month the following year. Kapoor expressed surprise that while the number of insured farmers has gone down, the profits of the insurance firms have increased significantly.

Public sector firm AIC earned Rs 2,610.60 crore in 2016-17, which was down to Rs 528 crore the following year.

Curiously, the AIC, which insured 2,46,83,612 farmers in 21 states in 2016-17, lost about one crore farmers as it insured only about 1.5 crore the following year. Kapoor alleged that the public sector's declining number indicated the growing clout of private insurance firms.

The data indicated that the number of insured farmers too dropped in the second year as 5,72,17,159 farmers were insured in 2016-17 against 4,87,70,515 farmers in 2017-18 — a decline of 84,46,644 farmers.

Devender Sharma, an agriculture expert, said this is an excellent scheme to earn profit for the insurance firms. "These are the new arhtiyas who need not to make any financial investment and earn massive profits."

BKU leader Gurnam Charuni alleged that this "flawed policy" has been framed intentionally to let insurance firms earn profit at the cost of farmers.

"The farmers being called beneficiaries have not got the insurance amount at all. Because most of them are loanee farmers, banks deduct the money a farmer gets for insurance cover against the loan as soon as it arrives."

About crop insurance scheme

Pradhan Mantri Fasal BimaYojana is a government-sponsored crop insurance scheme that primarily aims to provide insurance coverage and financial support to farmers in the event of failure of any of the notified crop as a result of natural calamities, pests and diseases.

TOP

Source

OPINION

Insurance for realty - Financial Chronicle – 15th November 2018

The roll-out of the Real Estate (Regulation & Development) Act 2016 (RERA) has been lauded as a watershed moment in the realty sector of India. The landmark policy reform is anticipated to change the functional dynamics of residential and commercial real estate transactions in the country.

Underlining the need to sustain consumer confidence and protecting investor interest in the realty sector, the RERA Act has stipulated the provision of 'title insurance', an indemnity policy insuring against issues related to disputed land titles, delays on account of long-drawn litigations and project cancellations. It has been mandated that all new and in-progress real estate projects registered under RERA should have title insurance. Developers have been directed to take title insurance under Section 16 of the RERA Act.

A fragmented, unregulated property sector to date had not made it a compelling factor to introduce a comprehensive, full-fledged title insurance product in India. With the roll-out of RERA to regulate real estate transactions in the country and ensure coverage and safeguards from financial losses on account of title defects, the concept of title insurance is widely gaining ground. With a view to cash in on the emerging business opportunity and leverage its market potential, prominent insurance companies in the private and public sector have expressed their willingness to launch specifically-tailored Title Insurance products and register them with the insurance regulator.

One of the India's largest insurance provider in the private sector, HDFC ERGO, has launched a Title Insurance Policy, the first such title insurance product introduced by an Indian private sector insurance player. The product is meant to provide indemnity coverage to developers and property owners from defective title-driven risks and losses. Public Sector player The New India Assurance Company Ltd (NIAC) has also launched a similar Title Insurance product. The policy would also cover litigation costs arising out of title defects.

The world over, title insurance has rapidly emerged as a widely accepted risk management tool and a multi-billion dollar business, especially in western countries. In the US and UK, Title Insurance forms an intrinsic part of all real estate purchases and consumers commonly buy it when entering into a transaction.

In India, RERA has stipulated that title insurance will have to be bought by developers while starting a project but once the construction is completed, it will need to be transferred to flat owners of the society management association. The US and UK have a robust digital land records infrastructure. It will take some time before India can leverage the full benefits of a comprehensive title insurance policy as the domestic real estate sector continues to remain fragmented and mired in lack of operational transparency and uniformity in transactions. The absence of a centralised land records database in the digital format has not helped resolve the situation.

Though title insurance has been broadly welcomed by all the stake-holders in the real estate sector, its practical execution is being questioned given the exorbitant cost of the insurance. It is estimated that the title insurance premium cost would take into account not just the land value but the entire gross development value of the project.

Developers are expected to pay an upfront hefty fee linked to the project development value for availing of title insurance for their projects. As the potential premium would add to the per sq. feet cost of housing projects and vastly increase the property price, the consequent burden would be passed on to home buyers. With insurance companies needing to undertake a cumbersome effort to authenticate the title and assess its veracity, the final transaction costs are likely to be inflated tremendously.

All the stake-holders in the real estate sector need to come together to ensure the successful implementation of title insurance as a viable risk management tool. The wider acceptance of title insurance by the industry will provide a huge boost to the Indian real estate insurance market and ensure greater accountability and transparency in the domestic real estate sector.

This would also give a boost to the securitisation market and also enhance the value proposition for debt instruments. This product will have a cascading positive effect on real estate industry as a whole and also the financial industry closely linked to the real estate.

(The writer is managing partner, SNG & Partners)

TOP

Source

Life insurers 'APE grows 10% in October – Financial Express – 15th November 2018

The annualised premium equivalent (APE) of life insurance companies grew 10% year-on-year to `5,741 crore in October. While private players witnessed higher growth at 18%, state-owned Life Insurance Corporation of India (LIC) saw a growth of just 3% (Y-o-Y) to `2,770 crore in October, data from Kotak Institutional Equities showed.

The first year premiums for the life insurance industry for October stood at Rs 15,480.47 crore, a gain by 11.58% compared to the previous financial year. In September, the industry had seen first year premiums down by 16.28% to Rs 17,490.68 crore, show the data the Irdai.

Participants in the industry say LIC is facing challenges in the group insurance segment in the current financial year. Irdai data show that in the current fiscal till October, LIC received first year premiums of Rs 73,637.64 crore, against Rs 77,977.72 crore in the previous financial year, a negative growth of around 5.57%. The decline in premium is higher in the group insurance business for LIC.

"Private sector individual APE saw growth at 17% Y-o-Y in October 2018. Most large players saw strong growth, with HDFC Life growing by 36% and Max Life up 27% Y-o-Y; SBI Life was moderate at 16%. However, ICICI Life reported a big decline (down 17% Y-o-Y) likely due to its focus on the lower-ticket business. With shifting focus to protection and other high-margin policies, VNB growth of large players will remain strong; nevertheless, APE growth for ICICI Life will remain a monitor able over the next few months," Kotak Institutional Equities said in a report.

On the other hand, the industry witnessed APE at 8% and private players at 13% for the period of April to October. APE is the sum of annualised first year premiums on regular premium policies, and 10% of single premiums, written by insurance companies during any period from both retail and group policyholders.

Players like Birla Sun Life Insurance, Bharti AXA, HDFC Life and India First continued to see their APE growth in positive during October.

The data from Irdai also show first year premiums of life insurance companies in the current fiscal surged by 2.41% at Rs 1.08 lakh crore, against Rs 1.05 crore in the corresponding period of the previous financial year.

TOP

Source

INSURANCE CASES

Insurance firm fined for refusing car claim - The Tribune – 14th November 2018

The consumer forum directed an insurance firm to pay over Rs 6 lakh to the complainant for refusing insurance claim of an Audi car. United India Insurance Company Limited was penalised after a firm, which had bought the car for its director, approached the forum.

OD Finance and Investment Private Limited, Solan, in its complaint stated that on July 31, 2013, they had purchased an Audi Q7 for the personal use of its director. The vehicle was insured from United India Insurance Company Limited for the period from August 2, 2015, to August 1, 2016.

However, on July 16, 2016, at 6.30 am, the vehicle was trapped in a waterlogged area near Don Bosco School, Alaknanda, and New Delhi. The complainant did not try to start the vehicle and got it towed to the nearest Audi workshop in Faridabad.

On August 25, 2016, an estimate of Rs 10.52 lakh was prepared for its repair. The complainant lodged the claim with the insurance firm, who appointed a surveyor. The complainant alleged that the surveyor tried to save the insurance company from paying the amount by furnishing a false survey report. The complainant thus paid Rs 8.14 lakh on its own for the repair work.

The insurance firm in its reply stated that the complainant was not a consumer as the firm purchased it for commercial use. It added that the vehicle was started in water, which was evident from the amount of water present on the top of its pistons, which can only happen after water is sucked in on being started. The claim was thus rightly declined, the insurance firm stated.

The forum, however, observed that claims of the insurance firm were not supported by any evidence. Hence, these were not taken into account. It added, "Policies are not issued for repudiating the claims on their whims and fancies or on the recommendation of the surveyor."

The forum thus stated that the claim had been wrongly rejected by the insurance company. The insurance firm was directed to pay Rs 5.94 lakh to the complainant, along with Rs 33,000 as cost of litigation.

The case

- In its complaint, OD Finance and Investment Private Limited, Solan, stated that on July 31, 2013, an Audi Q7 was purchased for the personal use of its director. The vehicle was insured by United India Insurance Company Limited
- However, on July 16, 2016, at 6.30 am, the vehicle was trapped in a waterlogged area near Don Bosco School, Alaknanda, New Delhi, developing a snag.
- On August 25, 2016, an estimate of Rs 10.52 lakh was prepared for its repair. The complainant alleged that the surveyor tried to save the insurance company from paying the amount by furnishing a false survey report.

TOP

Source

Pay Rs 20,000 to policy holder, insurance firm told – The Hindu – 12th November 2018

Holding United India Insurance deficient in services, a consumer disputes redressal forum here has directed the insurance company to compensate a policy holder by paying over Rs 20,000 for "wrongly repudiating" a claim.

Stating that the insurance company's contention that the policy holder's claim was under the "exclusion claim", the consumer panel said, "This forum is of the opinion that the ailment or disease of the complainant is not covered under [relevant] clause of the policy and the opposite party has wrongly denied claim. Thus, holding guilty of deficiency in services, we direct [insurance company] to pay Rs 20,000 as compensation for harassment and mental agony."

Complainant Kaushlender Ojha had alleged that despite having a mediclaim policy, the insurance company had refused to pay the claim of over Rs 31,000 raised by him.

"The complainant alleged that on account of... severe pain in the stomach, he approached Jaipur Golden Hospital through emergency and remained in the hospital and took treatment for [the] ailment," read the complaint in the order.

Further it was alleged that despite sanctioning the amount, the insurance company "unlawfully declined the payment of the claim" later.

The insurance company had however contended that resolving appendicitis "did not warrant hospitalisation" and hence, the complainant was not entitled to a refund of the claim. Dismissing the insurance company's contentions, the consumer panel has directed the company to compensate the policy holder by November 26, failing which an interest of 10% per annum will be levied.

TOP

Source

PENSION

'Banks, brokerages must be incentivised to promote National Pension System' - The Hindu Business Line – 12th November 2018

To incentivise points of presence (PoPs) such as banks and broking firms to enroll more people under the National Pension System (NPS), the Pension Fund Regulatory and Development Authority (PFRDA) should allow higher initial subscriber registration charge, according to a top official of a pension fund management firm.

Though this charge was raised to Rs200 in October 2017 from Rs125 earlier, the official said that it needs to be suitably hiked further so that PoPs feel incentivised enough to actively distribute NPS.

"If we evaluate the charge in terms of banks which have the maximum reach, probably it does not cover the employee cost for them...So, this is something which has to be fixed.

"...It is a laudable objective to reduce the costs but a balance has to be struck. If it (the charge) is not generating enough interest in the PoPs, which have the widest reach to propagate the scheme, if they don't feel incentivised enough, NPS penetration will continue to be low," said Kumar Sharadindu, MD and CEO of SBI Pension Funds.

NPS is a voluntary, defined contribution retirement savings scheme designed to enable subscribers to make optimum decisions regarding their future through systematic savings during their working life. The scheme seeks to inculcate the habit of saving for retirement amongst the nation's citizens.

PoPs perform the functions relating to registration of subscribers, undertaking know your customer (KYC) verification, receiving contributions and instructions from subscribers and transmission of the same in the NPS architecture. As on October 30, there are 134 entities, which have registered themselves as POPs for NPS. These include banks, broking firms, housing finance companies, and AMCs.

"While the fee for PoPs has been increased, it is not attractive enough. Otherwise, they would have been gung-ho, particularly in the existing challenging times which the banking industry, especially public sector banks, is going through. Any source of income would be highly welcome.

"As far as SBI is concerned, it does open the largest number of (NPS) accounts every year...But there are certain public sector banks which are not doing anything on this front. I would suppose, they don't see much incentive to do this (open NPS accounts) over some other things (such as recovery, as balance sheet strength comes from this activity)," said Sharadindu.

Out of the total subscriber base of 2.24 crore under the NPS as at July-end 2018, the 'all citizen' category, comprising individuals (other than those under the NPS Lite-Swavalamban and Atal Pension Yojana categories), accounted for only 7.22 lakh subscribers. In terms of numbers, the largest NPS subscriber category is the Atal Pension Yojana (1.07 crore). There were 59.21 lakh subscribers under the government category and 7.25 lakh subscribers under the corporate category.

As per PFRDA data, the total contribution under the NPS grew to Rs2,03,057 crore as of July-end 2018 against Rs1,98,530 crore as of June-end 2018. Government sector subscribers accounted for about 84 per cent of this contribution.

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Source

IRDAI CIRCULAR

Exposure Draft-Amendments to IRDAI(Appointed Actuary), Regulations, 2017 is available on IRDAI website.

TOP

Source

Updated list of life insurers is available on IRDAI website.

TOP

Source

First year premium of life insurers for the period ended 31st October, 2018 is available on IRDAI website.

TOP

Source

GLOBAL NEWS

Australia: Drought insurance could be public or private – Asia Insurance Review

In recent years, governments have focused on promoting private drought insurance markets. However, public schemes are also possible and exist in many other countries, say Mr. Neal Hughes, Senior Economist, Australian Bureau of Agricultural and Resource Economics and Sciences (ABARES).

In an article in *The Conversation*, he says that a well-designed public drought insurance scheme – with premiums to cover costs – might have some advantages over private insurance.

For example, governments may be better placed to absorb losses in years of severe widespread drought (although re-insurance markets might provide a way for the private sector to manage such risks).

However, public drought insurance schemes could, depending on their design, reduce demand for private insurance. This problem also extends to other forms of government drought relief: farmers may be less likely to pay for insurance if they suspect ad hoc drought assistance will be available.

Better data is essential

Ultimately, public and private insurance schemes face similar technical challenges. Solving these technical issues requires detailed data both on weather and farm outcomes, Mr Hughes says.

Numerous reviews have cited data limitations as a key constraint on the Australian farm insurance sector. A recent review by Australian Bureau of Statistics and ABARES highlighted the patchy and fragmented nature of existing government and industry agricultural data.

There is a good case for government to support the supply of this data, similar to the National Flood Risk Information Project established following the Australian 2011 floods. Investments in data are likely to have many applications beyond insurance, including the development of improved tools to support farm decision-making.

While drought insurance schemes have had mixed success to date, there remains some hope for the future. The emergence of big data collected from satellites and Internet-enabled devices promises to revolutionise both farm production and risk management.

In time, smart products underpinned by better data might finally help solve the challenge of drought policy, Mr. Hughes says.

TOP

Source

Singapore: Life insurers back medical fee benchmarks published by govt – Asia Insurance Review

The life insurance industry in Singapore is supportive of the Ministry of Health's (MOH) initiative to introduce a set of national benchmarks, starting with professional fees for medical procedures, says the Life Insurance Association Singapore (LIA Singapore).

LIA Singapore announced its backing in a statement yesterday following the publication by MOH of benchmarks for private sector professional fees for common surgical procedures. The benchmarks will guide private sector healthcare providers in charging appropriately and enable patients and payers to make more informed decisions.

The benchmarks were developed by the Fee Benchmarks Advisory Committee chaired by Dr Lim Yean Teng. The Committee was appointed by MOH in January 2018 to develop an approach for setting reasonable fee benchmarks, and recommend the fee benchmarks for surgical procedures and services. The Committee's recommendations have been accepted in full by MOH.

Wider strategy

The development of fee benchmarks is part of a larger strategy to ensure that healthcare costs remain affordable and Singapore's healthcare system sustainable. The initiative complements other measures, such as the publication of appropriate care and drug guidances, introduction of a co-payment requirement for new Integrated Shield Plan (IP) riders, and quality and cost benchmarking for the public healthcare providers. An IP is an insurance plan sold by private insurers that gives coverage additional to that offered under the government-run basic medical insurance scheme, MediShield Life, and provides the policyholder the option to be treated in private hospitals or higher class wards in public hospitals.

In developing the benchmarks, the Committee referenced data including actual recent transacted fees and inflation. It also considered other factors such as the complexity of the procedure, and the time, effort and expertise required of the professional for typical cases, so as to ensure that the fee benchmarks reflect a fair range of professional fees for the procedure.

To balance stakeholder interests and perspectives, the Committee consulted extensively with multiple stakeholders, including medical professionals, hospital administrators, advocacy groups such as the National Trade Union Congress and the Consumers Association of Singapore, and insurers and regulators.

Future phases of fee benchmarks

MOH will consult the Committee and relevant stakeholders to identify additional areas in which new fee benchmarks could be developed in future. The Committee will also look into the frequency and approach of how the published fee benchmarks could be periodically reviewed to ensure that they remain relevant.

Dr Lim said, "Ultimately, the effectiveness of the fee benchmarks developed will depend on how well it is accepted and used by the various stakeholders. As long as there is concerted and collective effort in applying them, the Committee hopes that it will help to moderate the rising healthcare costs in Singapore."

Stakeholders

The MOH encourages patients to use the benchmarks to have a conversation with their doctor on their treatment, the complexity of their condition and the fees charged.

Medical providers and professionals should take reference from the benchmarks to set appropriate charges and make reference to it when advising their patients.

The fee benchmarks also support payers such as insurers in taking an active approach in their claims assessment, product design and selection of preferred healthcare providers for their panel.

Insurers

LIA Singapore, in its statement, also said that insurers will have an additional reference point when reviewing whether the fees being claimed are "reasonable and customary". It will help to mitigate cases

of over-charging by providers and empower insurers to detect inflated claims and take an active approach towards claims adjudication.

The association said, "Going forward, panel arrangements remain an important initiative for IP insurers in Singapore. Such arrangements enable IP insurers and healthcare providers to work together to provide consumers an improved experience. The fee benchmarks will support efforts to manage overall medical costs by providing an additional source of guidance for IP insurers when establishing and working with their panels of preferred healthcare providers. Insurers are studying how the benchmarks will influence products in a way that is reasonable to other stakeholders, while ensuring that their healthcare protection plans remain sustainable in the long run."

TOP

Source

Australia: Commercial premium growth estimated at 7.4% this year – Asia Insurance Review

The current premium rate hardening in Australia's commercial insurance market is expected to continue into 2019, particularly in short-tail lines such as property, says Swiss Re Institute. Commercial premium growth is estimated at 6% next year, after a forecast 7.4% increase this year.

In a report titled "*The Australian commercial insurance market*", Swiss Re Institute also forecasts solid economic growth of 2.6% next year, which will support demand for insurance.

By line of business, the report says that premium growth in the motor and property lines is expected to be mainly rate driven. Financial lines will face capacity constraints and higher premium rates due to rising class actions.

Marsh's latest global insurance market report indicates that on average, commercial insurance rates rose by 13.7% year-on-year in the second quarter of 2018, after an 11.6%-gain in the first quarter, the highest among all regions globally. The increase was most notable in the small- and medium-sized enterprise (SME) segment. The stronger rates pushed premiums up 11.9% in the first half of 2018, after a 4.3%-increase in 2017.

Australia's commercial insurance market is the 10th largest in the world. Total segment premiums were $10bn in 2017. Despite its size and ranking, surveys indicate still significant scope for strengthening of the business sector risk management discipline in Australia. Disruption to operations is one of the key risks facing business today and an area where many Australian firms, particularly SMEs, are underinsured.

Opportunities

Swiss Re Institute sees this trend increasing in the face of disruptive technology. Cyber risk is becoming an increasing area of interruption concern. Digital connectivity, increased use of data and proliferation of sensor technologies in production facilities mean higher exposures to cyber threats.

Concern about business interruption (BI) among risk managers has also risen as a result of globalisation. Most multinationals and even mid-sized firms have agreements with a number of input and service providers across the world, and thus more supply-chain vulnerabilities. Survey findings show that 36% of Australia's top 2000 companies have investments overseas, on average in 4.2 foreign markets. Another survey shows that overall; close to 90% of Australia's SMEs have no BI cover of any sort. This represents a significant exposure weakness, given that collectively SMEs account for about 57% of the value of national industry and services sector output.

There is also rising interest in parametric insurance products. In Swiss Re Institute's view, non-physical damage business interruption (NDBI) is the next step in the evolution of solutions for exposures that have been difficult to insure.

Over time, the nature of insurable property risks has broadened from traditional property damage (ie, buildings and machinery) to BI and contingent business interruption. Innovative NDBI insurance solutions can further expand the scope of insurability by helping improve the efficiency of risk transfer, and also reduce earnings and cash flow volatility. For instance, the renewable energy sector, which is highly capital intensive with significant property and operational risks, stands out as a new technology that requires innovative insurance solutions.

TOP

Source

China: Insurance market stays flat in first 9 months – Asia Insurance Review

Total insurance premiums in China in the first nine months of this year totaled CNY3.07trn ($440.6bn), showing flat growth of 0.67% compared to the corresponding period last year, according to statistics released yesterday by the CBIRC.

In contrast, the insurance industry grew at double-digit rates in January to September in the last five years.

For the first three quarters this year, non-life insurers reported premium income of CNY880.8bn, representing an increase of 12.68% over the corresponding period last year. Life insurers posted gross premiums of CNY2.19trn, which was a decline of 3.48%.

By major classes of business, the gross premiums generated by non-life insurers reached CNY800.3bn, an increase of 10.69%. Life insurance saw a fall of 7.6% in premiums to CNY1.7trn. Medical insurance premiums totalled CNY433.7bn, jumping by 21.0% while accident insurance raked in premiums of CNY83.1bn, growing by 18.1%.

In total, property and personal insurance companies paid out CNY912.9bn in compensation and benefits, which represented an increase of 9.6%.

Insurance companies reported invested funds of CNY15.9trn at 30 September, an increase of 6.4% from the start of the year. They had bank deposits of CNY2.3trn (14.4% of the total investment portfolio), bonds of CNY5.5trn (34.8%), stocks and funds of CNY2.1trn (13%) and other investments of CNY6trn (37.8%).

At 30 September, the industry had combined assets amounting to CNY17.9trn, up by 6.7% from the beginning of the year.

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South Korea: Domestic insurance market is saturated – Asia Insurance Review

South Korea's domestic insurance market is reaching saturation, says global consulting firm McKinsey & Company.

In a report released on 7 November, McKinsey & Company warned, “The emerging insurance markets, such as China and Brazil, marked a high growth of 12% to 15% on-year last year, but the US, South Korea and Japan, which have already a matured market, had only 1% to 2% of growth over the same period. The markets of South Korea and Japan, which have a rapid pace of aging population, will continuously show a slowdown of growth.”

In fact, earnings and original premiums in the domestic insurance industry are steadily falling, reports *Business Korea*. The Korea Insurance Research Institute recently gave a worrying outlook that Korean insurers’ earnings and original premiums will decrease by 0.8% next year, which would be the third consecutive year of decline.

Profit fall

In particular, the institute has predicted that in 2022, compared to 2017, the profit before tax of life insurance companies will fall by 57%, or KRW6trn to KRW3.4trn (US$5.3bn) and that of non-life insurance companies will plunge by 75% or KRW5.7trn to KRW4.3trn. As the implementation of the International Financial Reporting Standard 17 has dragged down the sales of saving insurance products, both life insurance and non-life insurance companies are experiencing slower growth.

An official from the insurance industry said, "With the fall in guaranteed minimum interest rates due to low interest rates, introduction of the IFRS 17, reorganisation of sales commission systems and reduction of tax benefits, the purchase rate of life insurance and general saving insurance products in the non-life insurance sector will greatly decrease. In addition, the original premiums of non-life insurance companies practically show stagnation with an annual average growth of 0.4%. As the insurance purchase rate per household surpassed 90%, the insurance market has reached saturation point."

The official said that the insurance industry is looking at new segments for growth, like the pet market, but it is hard to blindly increase the market because the ratio of risks has not been ascertained yet.

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