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INSUNEWS

- Weekly e-Newsletter

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• Quote for the Week •

"Twenty years from now you will be more disappointed by the things you didn't do than by the ones you did so. So throw off the bowlines. Sail away from the safe harbor. Catch the trade winds in your sails. Explore. Dream. Discover."

– Mark Twain

INSIDE THE ISSUE

Insurance Industry

IRDAI asks insurers to disclose voting policy –The Times of India – 23rd March, 2017

Insurance companies, including LIC, will now have to publicly disclose their voting policy on resolutions in companies, where they hold stakes. The insurance regulator has asked companies to exercise their "independent judgement" and not to automatically support the proposals made by the board of the investee company.

The directives notified on Wednesday are part of the Insurance Regulatory and Development Authority of India's guidelines on 'stewardship code' for insurance companies. The code is aimed at providing insurance companies a framework for using their power as institutional investors. The new directive is significant considering that the LIC played a significant role in recent boardroom battle involving the Tatas and former group chairman Cyrus Mistry.

Market regulator Sebi has also been nudging IRDAI to get insurance companies to publicly disclose their voting on resolutions, with the objective of improving corporate governance.

One of the key guidelines of the code requires all insurance companies to publicly disclose their policy for maintaining conflict of interest in a way that policyholder interest is always given priority. "The company's policy should identify scenarios of likely conflict of interest as envisaged by the board, and should also address how matters are handled when the interests of clients or beneficiaries diverge from each other," IRDAI said.

While insurance companies are not expected to interfere in management, they are required to state publicly and in advance, at what stage they will intervene in running of a company — to protect policyholder interest. "Instances when insurers may want to intervene include, but are not limited to, when they have concerns about the company's strategy, performance, governance, remuneration or approach to risks — including those that may arise from social and environmental matters," IRDAI said.

Source

The regulator has also asked insurance companies to come up with a policy for acting in concert with other institutional investors." For issues that require larger engagement with the investee company, insurers may choose to act collectively with other institutional investors in order to safeguard the interests of their investors. For such situations, insurers should have a policy to guide their actions and extent of engagement," IRDAI said

Back

India: Insurers get green light for Reits, infrastructure trusts – AIR – eDaily – 20th March, 2017

The insurance regulator, IRDAI, has cleared investment by insurance companies in Real Estate Investment Trusts (Reits) and Infrastructure Investment Trusts (InvITs), thus making an important breakthrough for the sponsors.

In a circular dated 14 March 14, IRDAI said an insurer could invest not more than 3% of its fund size or in not more than 5% of the units issued by a single REIT/InvIT, whichever is lower.

Insurers can invest in units of REITs and InvITs that are rated not less than AA. They will form part of approved investments. REITs and InvITs rated less than AA shall form part of other investments.

Source

However, no investment can be made in REITs and InvITs where the sponsor is under the promoter group of the insurer.

Back

India: Regulator plans online insurance accounts for all by end-2018 – AIR – eDaily – 21st March, 2017

The insurance regulator IRDAI is planning to make it mandatory for all policyholders to have electronic insurance accounts by the end of 2018.

The regulator is currently rolling out a road-map for the insurance sector to ensure a smooth transition of policies from physical to digital format, reported moneycontrol.

The objective of creating an online insurance account is to provide policyholders the facility to keep insurance policies in electronic form, and to undertake changes, modifications and revisions in the insurance policy with speed and accuracy.

In segments like motor insurance, IRDAI has said that all policies will have to be issued in electronic format. For other policies, insurers have been asked to give an option to individuals in the proposal form to have a digital policy.

At present, less than 2% of the policies sold in the country are in electronic format. Private life insurer India First Insurance launched the first digitised policy in September 2013.

The e-accounts are maintained by insurance repository companies. If the particular repository has tied up with all insurers, the policyholder can access all his insurance policies on one platform.

According to estimates, about INR150 (US$2.29) to INR200 per policy is spent by insurance companies annually on maintaining policies in paper form. If all insurance policies are digitised, the industry could save about INR1 billion a year.

The four IRDAI approved insurance repositories are NSDL Database Management, Central Insurance Repository, Karvy Insurance Repository and CAMS Repository Services Limited.

Source

Not all insurance companies have tied up with these repositories. The country's largest insurer, Life Insurance Corporation of India, has launched its own platform for e-services which will offer a multitude of services including electronic policies.

Back

Govt mulling 100% FDI in insurance broking – Business Lines – 21st March, 2017

The government is considering allowing 100 per cent foreign direct investment in insurance broking with a view to giving a boost to the sector and attracting more funds.

The FDI policy, at present, allows 49 per cent foreign investment in the insurance sector that encompasses insurance broking, insurance companies, third-party administrators, surveyors and loss assessors as defined by the Department of Industrial Policy and Promotion.

An official said that representations have been made to the government that insurance brokers should be treated at par with other financial services intermediaries, where 100 per cent FDI is permitted.

"Insurance broking is like any other financial or commodity broking services. The issue was recently discussed in an inter-ministerial meeting. The government is positively looking at the matter," the official said.

The official, however, clarified that the FDI cap for insurance companies would remain at 49 per cent.

Further, industry experts stated that the insurance sector is being impacted due to weak distribution networks. There is a need to strengthen the distribution network to support the sector as a whole.

According to Prudent Insurance Brokers Director Pavanjit Singh Dhingra, the decision would help strengthen distribution as it is not a capital-intensive business.

The removal of foreign investment limit will encourage more players in the market with high technology, he said, adding it will help increase insurance penetration in India.

Source

Insurance penetration in the country was 3.4 per cent in 2015 against the world average of 6.2 per cent. It was 3.3 per cent in the country in 2014.

Back

G20 to jointly fight bank sector hacking – AIR – Asia Risk – 22nd March, 2017

The world's biggest economies will pledge to jointly fight cyber attacks on the global banking system, one of the largest coordinated efforts yet to protect banks after the $81 million heist of the Bangladesh central bank's account last year, reported Reuters.

At a meeting in the German town of Baden-Baden last week, the G20, which includes among its members Australia, China, India, Indonesia, Japan and South Korea, agreed to fight attacks regardless of their origin and promise cross-border cooperation to maintain financial stability, according to a draft document seen by Reuters.

"We will promote the resilience of financial services and institutions in G20 jurisdictions against malicious use of information and communication technologies, including from countries outside the G20," it said.

However, it dropped an earlier reference for enhanced security requirements for financial services, reported Reuters.

Cyber crime became a top priority after an elaborate heist on the Bangladesh central bank's account at the Federal Reserve Bank of New York last year, an unprecedented theft that exposed the vulnerabilities of the system. The agreement comes after a swirl of cybercrime controversies, including the US charging two intelligence agents from Russia with the theft of 500 million Yahoo accounts in 2014, alleged Kremlin-backed hacking of the 2016 US presidential election and attacks through the global SWIFT Bank transfer system.

Source

The European Union is considering testing banks' defenses against cyber attacks with concerns growing about the industry's vulnerability to hacking.

Back

General Insurance

3-year third-party insurance premium at car registration? – The Times of India – 22nd March, 2017

The national insurance regulator and General Insurance Corporation (GIC) will come out with a policy that will make it mandatory for everyone buying a new vehicle to pay third-party insurance premium for three and five years for cars and twowheelers, respectively , at the time of registration.

They will also design and market separate policies for third-party , owndamage and comprehensive vehicle insurance.This will allow vehicle owners to choose any of the products over and above the third-party insurance, which is mandatory .

It will also help states compel owners to have third party insurance for their vehicles.

Third-party insurance premium is only around one-third of the total premium one pays for composite insurance cover. Insurance Regulatory and Development Authority (IRDA) and GIC assured these steps to a Supreme Court committee on road safety after the panel made these recommendations.

These moves gain importance in view of the fact that over 45% of the vehicles plying on Indian roads are uninsured and victims of road crashes involving such vehicles run the risk of getting no compensation. This is far more critical as more than 60% of two-wheelers have no insurance cover and these vehicles are responsible for every fourth road death in India. GIC has told the SC panel that till December end, about eight crore of the total 14 crore vehicles plying on roads had insurance cover. It has also urged the panel to instruct state governments to carry out checks and identification of uninsured vehicles on a quarterly basis.

Source

Earlier this month, a parliamentary standing committee had recommended to the government to consider a framework to make third-party insurance a one-time affair, as is the case with the vehicle registration tax. It had suggested that everyone buying a new vehicle should be made to pay the amount at the time of registration.

Back

India: United India Insurance to launch IPO in FY2018-19 – AIR – eDaily – 22nd March, 2017

State-owned United India Insurance is looking at the early half of FY18-19 to launch an initial public offering, according to its newly appointed Chairman and Managing Director, Mr A V Girijakumar.

"But it might also be earlier, if market conditions are favourable and we are able to achieve our goals," he said in an interview with Times of India.

Mr Girijakumar, who was previously a director and General Manager of the company and who has over three decades of experience in public-sector insurance, was appointed to the insurer's top post this week.

He said that United India's IPO would be after those of New India Assurance and GIC Re that are scheduled this year.

He said that United India is particularly looking at cutting underwriting losses from group health business. He added: "There will be price revisions in group health. Now, this might lead to a loss of business and clients might seek out a cheaper insurer. But we are willing to take the risk. We are serious about cutting our underwriting losses and we are okay with doing less business; and exercising more prudence."

"Since we are going to focus on quality more than quantity, our growth might be a little lower; somewhere between 5-10%," he said. This means a target of INR157.5 billion to INR165 billion for FY17-18 in terms of gross premium.

Source

For the financial year ending 31 March 2017, the company has already crossed INR150 billion (US$2.4 billion) in gross premium, exceeding its target of INNR144.44 billion for the year. The insurer has increased its market share from 13.20% at the end of March 2016 and expects to exceed 13.65% by 31 March 2017.

Back

Consolidation of insurance firms calls for drastic overhaul of the system – Financial Chronicle – 21st March, 2017

As reported by Financial Chronicle in its Monday edition, the government is considering consolidation amongst three of the four general insurance companies where it currently owns a majority stake. This move comes at the back of government intention to take these companies public. We believe that it makes imminent sense for the government to pursue this consolidation before taking them for listing on bourses. There are multiple reasons for taking this position. First, the hard reality is that despite being around for years, government-owned general insurance companies have proved to be grossly inefficient. Whether on financial or operational parameters, these entities have under-performed when it comes to utilisation of capital. In one such insurance company, the situation is such that while premium collections are rising, net profit has dipped sharply in the last two years. In another case, the company does not match the solvency criteria as laid down by insurance sector regulator.

This inefficiency becomes starker when compared to working with some private sector non-life insurance companies, which have been around for just a decade, but have gobbled market share at a much faster rate and are also far better placed when it comes to utilisation of capital employed. Little wonder that today they are making an attempt at merger so that they can improve their balance sheets. A part of why these firms remain inefficient is because they are public sector companies. By definition, they hardly seek business or do production innovation in an industry, which even the regulator accepts that solicitation plays a big role in sales. Another reason for the low operational profitability is because these insurance companies have been fighting each other for whatever business comes to them sitting across the table – and this mind you, without the kind of balance sheet strength needed to fight a long battle in the insurance sector. With consolidation, two important things can happen. First, the operational cost of the merged entity is going to dramatically come down. At the moment, there is high amount of duplicity in the physical infrastructure between these companies. A merger will reduce this duplicity and add to net margins of the merged entity. Globally, insurance is largely sold online and that requires a strong balance sheet. It is only in India where human element dominates insurance sales. Over a period of time, that too will change and when that happens with a stronger and bigger balance sheet, state owned entities would be able to give real competition to private sector players. But the one thing, which our policy makers need to ensure, is that consolidation should not be in terms of financial merger of companies. The government needs to go in for a complete recast, which gets in more industry professionals to the merged entity and lateral hire from other private companies. Today, the biggest reason why public sector insurance companies don't get the best talent in the industry is because compensation levels at state-owned companies are

Source

extremely low. Unless the government does not fix these issues, there is little hope of any structural change in the way these companies work. The government would be well advised not to think too much about the modality of the consolidation because its biggest beneficiary would be government itself.

Back

Non-life, health insurance: Norms eased for recruiting PoS persons – Business Line – 17th March, 2017

The Insurance Regulatory and Development Authority of India (IRDAI) has eased norms for recruitment of Point-of-Sales (PoS) persons by non-life and health insurers.

With effect from April 1, insurers/ intermediaries will be allowed to appoint PoS persons with the mandatory training and passing of NIELIT examination, which is already being allowed in the case of life insurance.

The insurers, however, should ensure that the applicant for PoS position is not engaged with any other insurer or insurance intermediary by cross-checking with the database of the Insurance Information Bureau.

Source

They should also conduct an in-house training of 15 hours for the candidate which would be followed by an exam.

Successful candidates should be engaged as PoS persons by entering into a written agreement, which would specify the terms and conditions, the circular added.

Back

Check before you hire: Insurance company may reject your claim if your driver's licence is fake – The Times of India – 19th March, 2017

When we employ a driver for our vehicle, we take a copy of his driving licence in good faith, believing it to be valid and proper. But how many of us check whether the licence is genuine or fake? Unless a proper inquiry is made at the RTO which has issued the licence, the employer remains blissfully unaware of the fraud.

What happens when the driver is involved in an accident? If the insurance company investigates the claim and finds the licence to be fake, the claim is repudiated. The owner of the vehicle, who was deceived by the driver, has to suffer the loss as the insurance company may refuse to settle the claim.

Case Study: Shakir Ali owned a truck which was insured with Oriental Insurance for Rs 8,88,000. When the vehicle was transporting granite stone to Guwahati in Assam, it toppled while going over a damaged bridge at Barol in Ferozabad. The insurance company was intimated, which appointed a surveyor to assess the loss.

The truck was repaired at a cost of Rs 34,700, but the claim was not reimbursed. Some time later, the same truck caught fire. One again the insurance company was intimated and a claim was lodged, but the insurance company failed to settle it despite submission of all the relevant documents.

Ali had a legal notice issued, but the insurance company ignored it. He then filed complaint before the district forum for both the claims. In his complaint, he also included the cost of the damaged cargo, and compensation for harassment, totally amounting to Rs 11,75,650. He also sought interest and litigation costs.

The insurance company contested the case. It contended that driving licence which was held by Umesh Chandra, the driver of the truck, was purportedly issued the Guwahati RTO, but inquiries revealed that no such licence had been issued. So the company contended that the claim had been rightly repudiated.

The district forum overruled the objections and ordered the insurance company to pay Rs 8,21,050 along with interest, compensation and costs.

The insurance company's appealed against this order, but it was dismissed by the Uttar Pradesh State Commission. The company then filed a revision, contending that two of its investigators had made inquiries with the RTO which was supposed to have issued the licence and had found that the licence was fake. This had also been endorsed by the district transport officer who stated that no such licence had been issued by the RTO. Ali, on the other hand, claimed that there was no negligence on his part as he had checked the licence of the driver engaged by him, and had found that it had been renewed twice.

The National Commission considered various Supreme Court decisions on fake and forged driving licences. In National Insurance v/s Harbhajan Lal as well as in National Insurance v/s Laxmi Narain, the Apex Court had held

that the claim in not payable when the licence is fake. In United India v/s Davinder Singh, the Apex Court had held even if a fake licence is subsequently renewed by the authorities, it would not be considered to be a valid licence, and the claim could be repudiated. So the National Commission concluded that Ali's first claim had been rightly repudiated, and that the direction to settle it was incorrect.

Accordingly, by its order of March 6, delivered by Dr B C Gupta for the bench along with Dr S M Kantikar, the National Commission set aside the orders of the district forum as well as the state commission, and dismissed the complaint, holding that the insurance company had rightly rejected the claim.

Source

Conclusion: People must verify the driving licence of their drivers from the RTO. This can be done by making an application under the Right to Information Act. If you fail to take this precaution, you may end up without insurance coverage even with a valid policy.

(The author is a consumer activist and has won the Govt. of India's National Youth Award for Consumer Protection. His email is jehangir.gai.columnist@outlook.in)

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Health Insurance

Reliance Capital to carve out health biz from general insurance, plans to bring in global equity partners – The Economic Times – 16th March, 2017

KOLKATA: Reliance Capital has announced plans to carve out retail health insurance business from its subsidiary Reliance General Insurance Company to increase its stake in India's growing health insurance sector.

The company also has plans to bring in global equity partners to unlock value in the company in the future.

The board of the general insurance company has approved the proposal to form Reliance Health Insurance Ltd, which will, for the time being, be a wholly owned subsidiary of Reliance Capital, the Anil-Ambani led Reliance Group company.

The plan, however, requires approvals from Insurance Regulatory & Development Authority of India.

"The proposal will enhance management focus on health insurance and provide flexibility to the company to unlock value by bringing in global leaders in this space as strategic and equity partners," the company said in a press statement.

Health insurance in India has been amongst the fastest growing insurance verticals and annual premium is expected to nearly double to nearly Rs 50,000 crore by 2020.

Source

Reliance's general insurance business had gross written premium of Rs 570 crore as of March 31, 2016 through its network of over 175 branches across the country.

Reliance Capital has hired Ravi Viswanath as the CEO-designate of the proposed company.

Back

Corporate covers might get more expensive, as insurers tighten purse strings – The Times of India – 22nd March, 2017

Looking to buy a group health insurance? Don't be surprised if you are asked to shell out more towards the premium. This category of mediclaim is set to become expensive, as insurers gear up to increase premium rates by 15-20% this April. Most large corporates sign up for group health policies for their employees around the close of the financial year.

For most insurers, group health is at times a loss making proposition. "This is not just because these policies are competitively priced lower (large volumes expected to compensate lower pricing), but also because of higher than expected healthcare inflation," said Sanjay Datta, chief - underwriting and claims, ICICI Lombard General Insurance Company.

The pricing war in group health has severely impacted underwriting profits at insurance companies, including public-sector giants who have seen losses between Rs 900-Rs 1,800 crore just for the half-year of 2016-17. But as health continues to be a leading driver of growth (21.3% growth to Rs 27,457 crore in 2015-16), insurers can't

afford not to be in the business. So their rethink of pricing strategy to cut underwriting losses, might result in highers costs for corporate employers and employees (in co-payee policies).

United India Insurance CMD A V Girijakumar said, with loss ratios upwards of 110% it would no longer be viable to continue doing business at the same rates. "There will be price revisions in group health. Now, this might lead to a loss of business and clients might seek out a cheaper insurer. But we are willing to take the risk. We are serious about cutting our underwriting losses and we are okay with doing less business; and exercising more prudence," said the United India CMD.

"We are paying more than what we collect. We are paying close to Rs 4,620 in claims after collecting about Rs 4,200 in gross premium," said an executive.

Overall, group health covers 16% (5.7 crore) of total lives insured in India — with government schemes forming the majority at 76% (27.33) and individual retail health at 8% (2.87 crore). But in terms of premium collected, group health has a larger share. The industry sees 48% of revenue (Rs 11,621 crore) from group health, 42% from individual retail and 10% from government-schemes. Group health while being high on revenues is also high on claims. While individual business has a healthy claims ratio of 77%, and government-schemes have a slight

worrisome 109%, losses from group health are at 120%; which would mean for every Rs 100 the insurer writes as premium, it is paying out Rs 120 in claims).

Private insurers like Bajaj Allianz and ICICI Lombard have also adopted a similar model, where they are willing do less business, but at better rates.

"We have a limited set of clients in the group space. But they are repeat customers as they know we honour all our claims. Our pricing is more expensive than the market, but it is realistic as it has proved sustainable," said Abhijeet Ghosh, head, health insurance, Bajaj Allianz General Insurance.

Source

Insurers say that they have had to increase premium costs, as hospitals are unregulated. "There is no curb on what hospitals can charge. So for some corporate policies, where there are sub-limits or co-payer option the premium hike would be 2-8%. The sub-limits could be a cap on room rent, surgeon's fees, etc. But for corporate policies without sub-limits, the inflation will be higher at 8-15%," he added.

Back

Global:Medical tourism to present huge opportunity for health insurers – AIR – eDaily – 22nd March, 2017

Eleven to 14 million patients travel overseas for medical treatment every year, driven by globalisation, accelerating advances in medical technology, medical inflation and rising affluence, presenting a big opportunity for health insurers, according to Mr Laurent Pochat-Cottilloux, Global Head of Health Reinsurance Partnerships, AXA, at Asia Insurance Review's 12th Asia Conference on Healthcare and Health Insurance, which ended yesterday.

To tap the growth in medical tourism, which continues to expand by 15%-20% annually, he said insurers need to conquer a steep learning curve covering pricing expertise and data, Third-party Administration (TPA) management, medical claims management, pre-existing conditions underwriting, and the global provider network. "Cross-border health insurance remains a complicated line of business due to environmental factors such as insurance fraud by doctors and patients, lifestyle issues such as diabetes, inefficient healthcare ecosystems, and ever growing costs of treatment, with some very high cost providers in certain locations," he added.

Mr Pochat-Cottilloux advised insurers to build features in their product designs that incentivise policyholders to opt for treatments in the most cost-effective locations, as well as be mindful of the customer journey when offering such plans, including cutting down unnecessary paperwork, ensuring call centres are well trained to handle customer queries and bundling differentiation features such as medical concierge and medical checkups in their offerings.

Speakers at the conference also addressed the game-changing opportunities in health insurance brought about by Asia's aging population, changing consumer purchasing preferences, as well as new technologies that are ripe for deployment to contain medical inflation and propagate disease prevention and wellness. The latter includes wearable and IoT devices.

Source

Mr Danny Yeung, CEO of Prenetics, a Hong Kong-based medical technology company that provides DNA testing technology to help doctors make more accurate diagnoses and better understand their patients, said more insurers are approaching his company to embed Prenetics' solution into their products. Two insurers - Prudential and Manulife - have adopted his solution and he expects more insurers to do so in the next few months.

Back

Asia: AI can upgrade medical insurers to become health coaches – AIR – eDaily – 21st March, 2017

Health insurers need to function as a complete healthcare partner rather than just a 'payer', as the use of Artificial Intelligence (AI) enables stakeholders in the health industry to deliver better patient engagement on the back of more insightful data.

On the opening day of the 12th Asia Conference on Healthcare and Health Insurance, delegates were informed of how increasing connectivity and automation has enabled new paradigms in patient care.

And given how the healthcare sector is transforming itself as a smart industry, health insurers have both the obligation and opportunity to increase its level of engagement with policyholders – as both a means to manage cost as well as make a difference to well-being of its customers through preventive care.

These may include the use of mobile health apps, wearables and tools to establish a strong connection between patients and healthcare partners. Additionally, insurers can engage in health coaching by using digital tools for patient engagement and shared decision making.

As patients bring their customer experiences from other sectors into healthcare, there is increased demand for information and self-empowerment. The use of AI can help to empower patients by lowering their health costs and waiting time at clinics through remote self-diagnosis.

The use of gamification in healthcare also empowers individuals with self-supervised exercise programmes which integrates fun and motivation with gamified self-therapy training.

Source

From a traditional insurance underwriting perspective, AI and Big Data can increase the complexity of questions which insurers can ask their customers; and crucially help predict and prompt the questions which insurers should be asking.

Back

Seeing lower claims, health insurers take heart from cap on stent prices – Business Line – 17th March, 2017

The capping of stent prices by the National Pharmaceutical Pricing Authority (NPPA) is bringing smiles not only to heart patients but also to health insurers.

The loss-making health insurance sector is expected to gain as it could reduce the claim payouts, industry experts say.

The NPPA had in February imposed a ceiling on the prices: Rs. 7,260 for bare metal stent and Rs. 26,600 for drug-coated one. The price was in the range of Rs. 45,000 to Rs. 1.21 lakh before the imposition of the cap.

"The move would result in reduction of around 25-30 per cent in total procedure cost. As hospitals will now have to separately bill the cost of stent, it will bring in transparency in pricing," Abhijeet Ghosh, Head, Health Insurance, Bajaj Allianz General Insurance, told BusinessLine. However, the exact impact on the quantum of claims outgo is difficult to ascertain immediately, he added.

IIB data

The data of Insurance Information Bureau (IIB) lends support to the allegation that corporate hospitals in metros cities could be involved in escalating cost of healthcare.

The top six metro cities reported 25 per cent of all the health insurance claims made in the country and received 30 per cent of total health insurance claim payouts.

The claim size too varied. At Rs. 43,324 and Rs. 36,034 Mumbai's and Kolkata's average claim size was significantly higher when compared to Bihar where the average claim size stands at Rs. 10,451. The data is

available only for 2014 and it must have gone up further now, feel insurers. The data reflects a significant disparity between the cost of healthcare in leading cities and rest of India. This simply means that a cost of procedure in a metro city is much higher when compared to treatment in tier II or III city or town.

Other insurers also agree that the capping of stent prices will be of help. "This is a good move and is expected to be gainful for health insurers and patients," said Sanjay Datta, Chief of Underwriting Claims and Reinsurance, ICICI Lombard General Insurance.

Source

Jyoti Punja, Deputy Chief Executive Officer, Cigna TTK Health Insurance also agrees. "Yes. It definitely helps," she said.

According to the government estimate, price control of stents will result in annual savings of about Rs. 4,450 crore for patients.

Back

Here's why your health insurance claims may get rejected – Mint – 23rd March, 2017

Health insurance, as we understand it, involves paying an annual fee (premium) for financially insuring your health and well-being, and covering medical treatment in the time of need. Unfortunately, such covers include and exclude a gamut of terms and conditions that vary from insurer to insurer, across policies as well as consumers. But no matter which product you choose to buy, lack of complete information regarding its utilization, and ignoring the list of exclusions, often leads to claim rejection—which can result in a huge financial shock.

In a bid to make some sense of terms and conditions, or exclusions, that you are likely to come across while purchasing, or using, a health insurance policy, the most common ones are explained below.

Initial waiting period: This is the first and the most common exclusion. Initial waiting period means that from the date of purchase of the policy to the period of 30-90 days (depending on your policy), any claim made by you will be rejected, though there might be exclusions for emergency situations.

Waiting period for pre-existing conditions: This clause means that any claim made for a pre-existing disease during the waiting period will be rejected. For example, if you had disclosed asthma as a pre-existing condition at the time of purchase and you make a claim for treatment costs incurred for the ailment, even after the initial waiting period of 30-90 days (depending on your policy) is over, your claim could still get rejected because your policy might state that you cannot make a claim for any cost associated with asthma for a period of 1 year from the date of buying the policy.

Be sure to enquire about, or check, the exact timelines associated with pre-existing conditions.

Specific waiting period: Another common waiting period, or fixed period, guideline is about the maternity cover. Some policies may have a specific waiting period for claiming maternity benefits. For example, if you bought a policy in June 2016, it may allow you to claim benefits after 9 months of the date of purchase. Some policies may have longer waiting periods of 24 or 36 months.

Apart from this, whether or not you have a specific ailment or you contract it in the future, there is a fixed list of diseases (depending on the policy) that have specific waiting periods associated with them.

Caps on diseases: Taking the example of asthma again, let's say you spend Rs1.2 lakh on asthma-related treatment, tests, hospitalization and medicines in a year and submit the documents to claim insurance, keeping in mind all the waiting periods. You might still find that the claim has been rejected, completely or partly, because your policy document also included a cap on the expenditure that can be claimed. If your policy caps the expenditure on a disease at, say Rs1 lakh, then you will not be able to claim the remaining amount. Being aware of this clause will help you plan recurring treatments wisely.

Permanent exclusions: This section in your policy document includes the entire list of exclusions that your policy will not cover under any circumstances. It could include diseases such as diabetes , sexually transmitted diseases, critical diseases such as cancer; or even expenses relating to treatment for emergency situations such as accidents, specific medicines that may be expensive, eye wear and prosthetic limbs. Treatment in intensive care units (ICUs) and critical care may also be in this list but it is possible to opt for policies with enhanced coverage that have a shorter list of permanent exclusions. Go through the list thoroughly to keep the relevant exclusions in mind and avoid surprises at the time of utilization.

Room eligibility: This may seem trivial but many policyholders get a shock when their claim is rejected, or only partially reimbursed, or only a portion is pre-approved because the room rent exceeds limit mentioned in the policy. Exceeding room rent limit means that if your policy states that only 1% of the total sum insured can be allocated to room rent charges at the hospital, then charges above 1% will not be eligible for insurance. For example, if your policy insures you for a sum of Rs5 lakh, you will be eligible for a room rent for Rs5,000 per day only. Most hospitals practice differential billing for medical expenses incurred, in line with the type of room you choose. Thus, if you choose a room that costs Rs6,000, the related medical expenses will also be charged accordingly but you will be able to use your policy for expenses associated with a Rs5,000 room only. The rest will have to be incurred out of pocket.

Source

While the real value of the policy can be measured when it is actually used, being mindful of the terms and conditions will certainly help you make more informed decisions and use your policy optimally.

Back

Pension

EPFO may invest up to 15 percent of investable amount in equity markets – The Financial Express – 19th March, 2017

Buoyed by the surging stock markets, the Employees Provident Fund Organisation (EPFO) may propose to invest up to 15 per cent of its investable amount in equity markets during the next fiscal, Union Labour Minister Bandaru Dattatreya said. "We are proposing to invest up to 15 per cent during the next year. Central Board of Trustees (CBT) meeting will be held on March 30. We will seek its opinion. So far, during the past one-and-half year we have invested Rs 18,069 crore. We are getting good yield. It is encouraging," Dattatreya told PTI.

According to the minister, so far in the current year, the Provident Fund body invested the amount in the two index-linked ETFs (Exchange Traded Funds) — the BSE's Sensex and the NSE's Nifty which yielded a return of 18.13 per cent. He said the investment proposal will be put in the CBT meeting to be held on March 30 for the final call.

Dattatreya said the EPFO through fund managers had invested 14,700 crore in ETFs in the current financial year. A senior official said the Ministry of Finance gave its consent to the EPFO to invest from 5 per cent to 15 per cent of the investable income of the organisation every year.

Source

Investable income is the net income of the EPFO from the investments it had already made in various forms, fresh contributions among others. This year the investable income would be about Rs 1.40 lakh crore, the official said. The EPFO had started investing in ETFs in August 2015. EPFO manages a corpus of over Rs 8 lakh crore.

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Circulars

Source

Guidelines on Stewardship Code for Insurers in India – Circular Ref: IRDA/F&A/GDL/CMP/059/03/2017 dated 22.03.2017

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Modification in premium rates due to revised Commission/Remuneration Structure and introduction of Reward System – Circular Ref: IRDAI/NL/CIR/F&U/060/03/2017 dated 22.03.2017

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Global

South Korea: Life insurers agree to honour suicide claims – AIR – eDaily – 17th March, 2017

South Korea's top three life insurers -- Samsung, Hanwha and Kyobo -- have decided to pay all overdue suicide claims, giving in to regulators' punitive measures.

The move came after the Financial Supervisory Service (FSS) decided last month to take punitive actions against the trio, which would include suspension of part of their business operations for up to three months. In addition,

they would be banned from acquiring firms and launching new businesses for three years if the state financial watchdog's decision is approved by the Financial Services Commission, the government's prime regulatory body, reported Yonhap News Agency.

The FSS also issued disciplinary warnings against Samsung Life Insurance's CEO Kim Chang-soo and Hanwha Life Insurance's CEO Cha Nam-gyu. Under relevant regulations, those with such a penalty cannot assume an executive post at financial firms here for three years. Their Kyobo counterpart Shin Chang-jae received a simple warning as the firm announced plans, albeit belated, to pay all unpaid benefits for suicide claims.

At issue are insurance policies sold by the insurers in the 2000s with a special contract, purportedly included by mistake, to recognise suicide as a disaster-related death, which would pay out higher compensation than in cases of general death.

However, the insurers refused to pay the suicide claims amid controversy over whether suicide is actually associated with any disaster.

Although the Supreme Court ordered the insurers to pay the claims in a 2007 landmark ruling, they argued the statute of limitations had already expired.

Source

The then-Donga Life Insurance, now KDB Life, sold the first policy covering suicide in 2001, and more than 10 other life insurers followed suit between 2003 and 2010. In 2010, the insurers changed the terms of their policies to exclude suicide. Except for the top three life insurers, the others had earlier agreed to pay the suicide claims.

The overdue payments that have not been made for suicide claims stand at KRW160.8 billion (US$142 million) at Samsung, KRW113.4 billion at Kyobo and KRW105 billion at Hanwha.

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