भारतीय बीमा संस्थान
INSURANCE INSTITUTE OF INDIA

INSUNEWS

Weekly e-Newsletter

7th – 13th August 2021

Issue No. 2021/32

QUOTE OF THE WEEK

"The winds and the waves are always on the side of the ablest navigators."

Edward Gibbon

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Personal Liability Insurance

Personal liability insurance is insurance coverage for liabilities that individuals, rather than organizations, may be held accountable for. Many homeowner's insurance policies and auto insurance policies include a certain amount of personal liability insurance coverage. Personal liability insurance, however, can also be purchased as a stand-alone policy.

There are many different types of liabilities that a person can be held accountable for. For example, if someone gets injured from a slip and fall on your property, or if your child hits a baseball through a neighbor's window, you could be held liable for both of these things. Injuries can often be very expensive to reimburse due to high medical costs, lost wages, and pain and suffering but personal liability insurance can help alleviate the cost of reimbursement.

INSURANCE INDUSTRY

What you should know about standard insurance covers – The Hindu Business Line – 7th August 2021

The outbreak of Covid-19 last year spurred awareness about insurance across all categories, particularly life and health plans, although choosing from amongst different policies has always been a daunting prospect. To make things easier for the consumer, insurance regulator IRDAI introduced guidelines for 'standard' insurance policies whereby the coverage, cover amount, features and riders will remain the same across insurers, including the policy name — the uniformity making comparison of features easier for the policyholder. The standard policies issued in the wake of IRDAI's initiative include Arogya Sanjeevani (health policy), Saral Jeevan Bima (term insurance), Saral Pension (annuity product), Saral Suraksha Bhima (personal accident), Corona Kavach, and Bharat Griha Raksha (home insurance). Standard benefit policies include Corona Rakshak and Mashak Rakshak, which provide cover for vector-borne-diseases. But despite the 'standard' tag, the policies may not suit all. You will still have to assess factors such as premium, personal and family needs, ease of on-boarding, medical check-up requirements and digital offerings — with variations across insurers.

Here, we seek to break down key standard insurance policies — life and health — to give you, the consumer, more clarity about what's on offer. It could also be that, in some instances, a non-standard product may suit you better. Read on, to get the full picture. Saral Jeevan Bima is a pure-vanilla term cover, which pays the sum assured (SA) in lump sum to the nominee in case of death of policyholder during the policy term. The nominee will receive the higher of 10 times the annualised premium, 105 percent of all premiums paid as on date of death, or absolute SA. In the case of single premium policies, higher of either 125 percent of all premiums paid or absolute SA is payable. As per guidelines, this policy comes with two rider options — accident benefit rider and permanent disability rider. Unlike other term plans, Saral Jeevan Bima features a waiting period of 45 days from the date of policy commencement. But during this period, death due to accident will be covered. In case of death by reasons other than accident during the waiting period, only the premium received (excluding taxes) will be paid to the nominee.

Term insurance is one of the simplest insurance policies that can be purchased, and standard term cover is the easiest of all to buy. It offers pure risk protection with no frills attached. As a general rule, it is

better to have a term cover that is 10-15 times your annual income. Since not many insurers offer Saral Jeevan Bima beyond ₹25 lakh, this policy may suit only low-income earners. For others, a regular term plan from insurers could be better. The advantage with existing term insurance plans is that they are competitively priced and offer wider cover. Yes, there are bells and whistles with term plans nowadays. While all features may not be needed, simple ones with built-in benefits available for no extra premium can be useful.

For instance, the yearly premium on Saral Jeevan Bima offered by ICICI Pru Life, for SA of ₹25 lakh for a 40-year term (30-year-old individual), works out to ₹12,312 (including GST) while premium on ICICI Pru Life's iProtect Smart for the same criteria for ₹50 lakh (minimum SA) works out to ₹9,987 per year (including GST). Additionally, iProtect Smart plan comes with waiver of future premium in case of permanent disability due to accident. Thus, for a wider cover, the premium for the iProtect Smart is lower than the standard product offered by the insurer.

According to industry experts, not all individuals will be eligible for buying a term plan due to lack of income proof, and due to their job profiles. Such individuals are likely to benefit more through Saral Jeevan Bima while others can consider regular policies. Do note, you should increase your term cover as your income increases. Your debts should also be considered while choosing SA in a term plan so that your family is not burdened with repaying them in your absence.

Standalone personal accident (PA) policies offered by almost all health and general insurers are specifically designed to cover disabilities, both permanent and temporary. The same coverages are offered as riders in term policies. A PA policy's claim amount depends on the type of impairment, which can be permanent or temporary in nature. The standard PA cover, Saral Suraksha Bima, too works in the same fashion. The policy pays the entire sum insured to the nominee upon the death of the policyholder due to accident, even if the death due to accident is caused up to 12 months from the date of the accident. Similarly, depending on the impairment (caused due to accident), the insurer pays the SI to the policyholder. For instance, in case of total permanent disability, 100 percent SI is payable to the policyholder, provided it occurs within 12 months from the date of the accident. The insurers also offer three riders under this policy — 1. temporary disablement, where 0.2 percent of SI per week is paid to the policyholder till he/she gets back to work; 2. hospitalisation expenses payable up to 10 percent of SI (provided it is due to accident) and 3. education grant, where 10 percent of SI per child is payable in lump sum, provided the age of the children is not beyond 25 years.

Like other PA policies, standard PA cover also comes with a cumulative bonus where the SI shall increase 5 percent up to 50 percent of SI, for each claim-free year, if the policy is renewed without a break. The sum insured can be ₹2.5 lakh to ₹1 crore. So, if you have opted for accidental rider or accidental disability cover in your term plan, you may skip PA cover, whether in the form of the standard Saral Suraksha Bima or standalone policies offered by insurers. While standard PA cover and other PA covers offered by insurers are similar, you can compare them on SI limits and premium. For instance, in case of standard personal accident cover versus global personal guard cover (PA) with Bajaj Allianz General, for ₹25 lakh, the premium is ₹2,650 and ₹2,625 per year, respectively (excluding GST). Note that there is not much difference in premiums here. Now, let's consider accidental death benefit rider of ₹50 lakh with a term cover of ₹50 lakh. In LIC's Tech Term, your total premium is ₹13,650 per year (excluding GST) where the term premium is ₹11,150 (₹50 lakh cover) and accidental death rider premium is ₹2,500. When you opt for accidental death (and disability) cover as a rider/optional cover with a term policy versus a standalone PA cover, there will be premium differences. But the differences are not significant. So, if you have a pure vanilla term plan without an accident cover as part of it and also have a base health policy, you can consider Saral Suraksha Bima itself for PA cover.

Arogya Sanjeevani covers all hospitalisation expenses as well as all day-care treatments, subject to some conditions. The standard policy too offers cashless facility to its policyholders, provided hospitalisation is in network hospitals. It too comes with minimum waiting period of 30 days and other disease-specific waiting periods. The policy also offers cumulative bonus. (i.e increase in SI if policyholders have not made any claim in a year). One, it comes with sub-limits for some expenses like room rent or ICU

expenses per day, beyond which insurer will not pay. Thus, even if you have, say, a ₹10-lakh cover under this policy, you may still end up paying from your pocket at the time of hospitalisation because of these sub-limits. Second, it has 5 percent co-pay clause on all claims. This is the amount the policyholder must bear in case of a claim. Many policies in the market have no sub-limits, especially on room rent which plays an important role in your claim amount, and also come with no co-pay across all age categories. Additionally, other features are offered in these policies, including unlimited restoration of SI, 100-200 percent no-claim bonus, annual (free) health check-up, inflation cover, daily cash allowance, and even OPD coverage.

The case against the standard policy may become more compelling when comparing on premiums. For a ₹10-lakh cover (family floater) in case of Manipal Cigna, for instance, the premium for Arogya Sanjeevani works out to around ₹11,129 (excluding GST). In contrast, the premium for the ProHealth plan (Protect version, family floater), is ₹10,364 (excluding GST). Pro Health offers in-built features including OPD coverage, annual health check-up, health rewards, expert opinion critical illness, and restoration benefit. There are no co-pay and sub-limits in this plan. Though the premium for Arogya Sanjeevani may work out cheaper in some cases, it can only act as a basic health cover. You can consider this as an add-on to your existing health policy or go for other standard covers such as Mashak Rakshak along with it. Mashak Rakshak, the standard vector-borne-disease policy, covers against dengue, malaria, filaria, kala-azar, chikungunya, Japanese encephalitis and Zika virus. Since it a benefit policy, if you are hospitalised for one of the seven vector-borne diseases, you will get the benefit from this policy and can also claim hospital expenses (if any) under your regular health policy. Do note that insurers including Bajaj Allianz General and HDFC Ergo offer standalone vector-borne-diseases cover as well. So it may pay to compare the premiums before signing up for Mashak Rakshak.

(The writer is Bavadharini KS.)

TOP

INSURANCE REGULATION

IRDA to insurance cos: Can't show premium as receivables beyond 270 days – CNBC – 7th August 2021

The insurance regulator, Insurance Regulatory and Development Authority (IRDA) has tightened the norms with regards to the crop insurance scheme. This has implications for a lot of listed entities as well. In a nutshell, as high as 20 percent of the total premium, which the general insurance companies collect altogether could come under uncertainty on the back of these new order and regulations from the insurance regulator.

What IRDA has said is that general insurance companies cannot show receivables from crop insurance premium if they are not collected or received within 270 days, which means these general insurance companies will have to mark down whatever remains pending in terms of receivables of crop insurance premium from various central governments and state governments if they are not received within 270 days. Now, just to set some context, crop insurance is a subsidised government scheme where 50 percent of the premium is paid by the farmer or the beneficiary and the balance 50 percent is shared between the central government and the state government. Now that 50 percent with central government and state government pays together is the amount that is under question, and which the insurance companies have been asked to collect within 270 days.

(The writer is Yash Jain.)

TOP

LIFE INSURANCE

YOUR MONEY: No customer stickiness: Both policyholders & insurers hurt by mis-selling - Financial Express – 10th August 2021

A life insurer seems to be in a perpetual dilemma over whether to focus on improving topline or bottom-line. Indian insurers have long decided to go for the topline. Even the regulators are appreciating the efforts of insurers in getting topline growth only. When they say that the industry has grown by 7.49% last year, what they refer to is the growth of new business. Although new business is the life blood of any life insurer, the overall health depends on total premiums received during a year which includes renewal premiums.

According to the latest annual report of IRDAI, renewal premiums consisted of only 54.75% of the total premiums received. This is abysmally low given the fact that the average premium paying term of a life insurance policy has been estimated to be about 15. This means, the renewal premium should be a few times more than the first premium. If the insurers earn less and less renewal premiums, they cannot generate enough valuation surpluses which in the insurance industry are considered a good proxy of profit from insurance business. If surplus is less, the bonus for policyholders will be less and dividends for shareholders will also be less. Since more life insurers are getting listed (including the market leader LIC), the emphasis is expected to shift towards building better bottom-lines.

Low renewal premium collection

It is a vicious cycle for the insurers at the moment. Since the collection of renewal premium is low, they have to be desperately looking for new business all through the year. In their acts of desperation, the tied agents and the corporate agents keep on selling products that many policyholders very soon find not of much use. Higher rate of lapsations and surrenders mean lower collection of renewal premiums. That means the insurers have to procure new business, no matter what the quality of that business is. This completes the vicious cycle. No wonder persistency ratios of almost all life insurers are low. While declaring the persistency ratio, many insurers mention the 13-month persistency ratio which is usually as high as 70% or even 80%. However, a policy contributes to the bottom-line of an insurer only when it is kept in force for a minimum of five years. Now, the 61-month persistency ratios are below 50% for all but two life insurers.

Lower cost of operations

Insurers will start focusing more on reducing operational expenses. Their digital infrastructures will be strong enough to support Work From Home options. Many of the interactions with the customers and intermediaries will be tech driven, resulting in lower operational expenses. There will be better use of digital marketing tools to sell and service the policies. To improve the bottom-line, certain things have to be addressed immediately. Insurers have to ensure that each policy is sold according to specific insurance needs. Customer engagement programmes should be set up to arrest cases of early lapsations and surrenders. Customers should not find any reason to be aggrieved with the insurers. Insurers cannot leave the job of maintaining proper relationships with customers only to agents. Gone are the days when the agents happened to be the best family friends cum financial advisors. Today's intermediaries do not have patience or energy to build the business. Data science has to be used more intensively to personalise products and services. In other words, the business model has to undergo a metamorphosis.

(The writer is Tushar Chatterjee.)

TOP

IRDAI says fasten life insurance claims settlement of Maharashtra flood victims – Live Mint - 9th August 2021

The Insurance Regulatory and Development Authority of India (Irdai) has called for quick and timely settlement of life insurance claims of victims of recent floods in Maharashtra.

In a circular, Irdai has asked insurers to designate a senior level officer as nodal officer in the state for coordinating/expediting settlement of all claims reported, who will establish contact with the state's chief secretary or the officer concerned for subsequent follow ups. Similar nodal officers will be designated for each of the affected districts to liaise with district administration, and intimate the contact details of all nodal officers designated to the Authority.

Insurers need to publicise the details of designated officers, special camps etc in the media and through the state government to facilitate expeditious filing of claims. They have been also asked to start 24x7 helplines, as required, with details sent to the Authority, immediately.

Special attention should be paid to to PMJJBY claims.
Further, a suitably simplified process/procedure including relaxations in the usual requirements wherever feasible may be considered to expedite claims settlement, Irdai said. With regard to claims involving loss of life, where difficulty is experienced in obtaining a death certificate due to non-recovery of body etc., the process followed in the case of Chennai floods in 2015 may be considered.

With a view to limit the fallout of the pandemic and limiting direct/indirect social contact, all life insurers have been advised to encourage and motivate policyholders/claimants to adopt e-modes, wherever possible, said the circular.

For policyholders/claimants coming to office, insurers have to follow government directions regarding maintaining social distancing and proper sanitisation. Staff must be duly sensitised to deal with policyholders/claimants with empathy and concern.

TOP

Life insurers report 11% YoY decline in new business premiums in July - Business Standard – 9th August 2021

After witnessing a marginal year-on-year (YoY) rise in new business premiums (NBP) in June, following a dip in May due to the second wave of the Covid-19 pandemic, the life insurance industry's NBP has again dropped in July.

This is mainly due to the contraction in business seen by the state insurance behemoth — Life Insurance Corporation (LIC) of India.

In July, life insurers — 24 in total — earned an NBP of Rs 20,434.72 crore, down 11-per cent YoY from last year. While private insurers managed to report a 7.53-per cent increase in NBP in July over last year, LIC saw its NBP contract almost 21-per cent YoY to Rs 12,030.93 crore.

In June, LIC reported an NBP of Rs 21,796. 28 crore, down 4.13 per cent on a YoY basis. Sequentially, i.e., on a month-on-month basis, LIC's NBP contracted 44.8 per cent. The dip in LIC's NBP was on account of a steep fall in individual single premium and group single and non-single premium.

NBP is the premium acquired from new policies in a particular year. When compared to the pre-pandemic period (July 2019), the NBP of the life insurance industry witnessed a drop of 5 per cent, with LIC NBP declining 21.42 per cent and private insurers' NBP posting a stellar growth of 35 per cent.

NEW BUSINESS PREMIUM OF LIFE INSURERS IN JULY

	July, 2021 (₹ cr)	YoY chg (%)	MoM chg (%)
Private insurers	8,403.79	7.53	2.31%
LIC	12,030.93	-20.70	-44.80%
Industry total	20,434.72	-11.10	-31.90%

NEW BUSINESS PREMIUM OF LIFE INSURERS IN FY22

	YTD July, FY22 (₹ cr)	YoY change (%)
Private insurers	25,528.36	23.80
LIC	47,631.62	-7.87
Industry total	73,159.98	1.16

Sources: Life Insurance Council, Irdai

On a year-to-date basis, the life insurance industry saw a marginal 1.16-per cent YoY growth in NBP to Rs 73,159.98 crore. While LIC's NBP till July totalled Rs 47,631.62 crore, down 8-per cent YoY, private insurers saw their NBP rise 24-per cent YoY to Rs 25,528.26 crore.

In the first quarter of 2021-22 (FY22), the premium collection of the life insurance industry was up almost 7 per cent to Rs 52,725.26-crore YoY, aided by a stellar 33.73-per cent growth registered by private insurers. However, LIC's NBP in Q1FY22 declined 2.5-per cent YoY to Rs 35,600.68 crore.

Due to the second wave of the pandemic, life insurers saw a muted first quarter (Q1), but business has since picked up — at least for private insurers. However, supply-side constraints remain and are expected to ease as soon restrictions lift.

Among the largest private-sector life insurers, while SBI Life insurance reported a 5.67-per cent YoY decline in NBP in July, HDFC Life saw a marginal 4-per cent YoY increase in NBP. On the other hand, ICICI Life reported a 36.31-per cent jump in NBP. Max Life's NBP was up 22.14 per cent in July on a YoY basis.

The life insurance industry has seen a spike in death claims in Q1FY22 due to a debilitating second wave, resulting in companies taking a huge hit on their profitability to set aside reserves to mitigate the impact of elevated levels of claims. While the claims burden has come down since Q1, the possibility of a third wave has kept insurers on tenterhooks.

(The writer is Subrata Panda.)

TOP

How to become insurance-free and make crores instead of paying pricey premiums? – Financial Express – 8th August 2021

Why do you buy a term life insurance policy? The most obvious answer anyone may give is to ensure the financial security of the family if something happens to the breadwinner. But, have you ever thought about other ways to achieve this goal of financial security?

Before the arrival of the concept of life insurance, people covered themselves and their families against financial uncertainties by building wealth in the form of Gold or land. When cash became the main driver of all financial transactions, people even hoarded cash in their homes to be ready for any unexpected life events.

But now there are multiple ways of building wealth or securing yourself against financial insecurities. While term life insurance is considered a good option for this purpose, Author Deepak Mullick has shown in his upcoming book "SimplyMutual: the 1% formula to gain your financial freedom" that you may financially secure yourself also by building a significantly large corpus by investing in equity mutual funds through a goal-based approach.

When Mullick became a first-time dad at the age of 30, he wanted to build a corpus of Rs 1 crore so that his family will get the amount if something unexpected happens to him.

After calculating all sources of his income, Mullick assumed he may be able to add a corpus of Rs 20 lakh every five years. So instead of buying a single term life cover of Rs 1 crore, he purchased five term life insurance policies of Rs 20 lakh each with 5, 10, 15, 20, and 25-year maturity.

Mullick had planned that he would keep ending a policy as soon as he would add an amount equal to its maturity value to his corpus. This way, every five years he would add Rs 20 lakh to his corpus and stop paying a premium for one policy. By 25 years, he would have a Rs 1 crore corpus for his family and won't need to pay the pricey premiums required for a term life insurance policy.

However, Mullick didn't have to wait for 25 years to build a corpus of Rs 1 crore. Mullick shares in the book that with a systematic approach he was able to build Rs 1 crore in just 7 years and cancel all the insurance policies! And that Rs 1 crore has grown into a lot more since then. If Mullick had purchased a term life insurance policy of Rs 1 crore, he might have ended most of his earning years in paying insurance premiums. But through clever planning, he not only became insurance-free but also grew his wealth "a lot more" than Rs 1 crore.

Mullick has shared several interesting insights on growing money in the book. The above one is particularly interesting as it shows it is possible to become insurance-free. However, one needs to always keep in mind that investing in mutual funds or equity markets is subject to market risks. And it is always advisable to take guidance from an experienced financial advisor before making investment decisions.

(The writer is Rajeev Kumar.)

TOP

GENERAL INSURANCE

General Insurance Amendment Bill: What it is about, and why the uproar over it - The Economic Times – 13th August 2021

The General Insurance Business (Nationalisation) Amendment Bill, 2021 was passed by the Rajya Sabha on August 11 amid major Opposition protests. The Lok Sabha had already passed it on August 3.

What is the bill all about?

The General Insurance Amendment Bill aims to push greater private participation in the public sector insurers. The bill seeks to remove the requirement that the Centre should hold not less than 51 per cent of the equity capital in such insurers.

Why the need for an amendment?

According to the government, the need arose to address such matters as (a) push for higher private participation in public sector insurance companies; (b) raise the level of insurance penetration and thereby social protection; (c) secure the interests of policyholders in a better manner; (d) contribute to faster growth of Indian economy.

What does the bill seek to amend?

The General Insurance bill seeks to amend the General Insurance Business (Nationalisation) Act, 1972. This law dealt with nationalising all private general insurers in the country. Under it, the General Insurance Corporation (GIC) of India — abbreviated as GIC Re — was set up.

National Insurance, New India Assurance, United India and Oriental Insurance became its subsidiaries. The Act was amended in 2002 and the Central Govt took over control of the subsidiaries from GIC. The new bill seeks to remove the old Act's proviso on the 51% government holding requirement.

Which insurers will be impacted?
India has four general insurers in the public sector. These are: National Insurance Company Limited, New India Assurance Company Limited, Oriental Insurance Company Limited and the United India Insurance Company Limited.

Major changes from the old bill
(i) Section 10B of the old Act was omitted to scrap the 51% requirement;
(ii) Section 24B, a new one, has been brought in, which says the Centre can relinquish control of a public insurer from a given date;
(iii) Section 31A, saying that a director who is not a whole-time director will be held responsible for acts of omission and commission by the insurer.

What does the Opposition want?
The government has been accused of not following parliamentary norms and "bulldozing" the legislation. Opposition parties demand that the bill be referred to a select committee of the House. According to the Opposition, the amended rules are going to prove detrimental to larger public interest.

When was the move first announced?
The late Arun Jaitley had first proposed to merge United India, Oriental Insurance and National Insurance, in his 2018 Budget speech. Such a merger would have made the united entity India's largest general insurer.

In July 2020, however, Modi Cabinet called off this merger proposal. In Budget 2021-22, Finance minister Nirmala Sitharaman unveiled a big-ticket privatisation agenda, announcing that "one general insurance company and two public sector banks" would be privatised.

What now?
The Bill will become an Act once it is gazetted. Thereafter, all the above mentioned public general insurers can be taken up for privatisation.

TOP

For a more level insurance market - The Economic Times - 12th August 2021

The amendment of the general insurance law to bring the government stake in State-owned insurers below 51% is welcome. The dilution of State ownership will lead to better standards of reporting, level the field for private insurers, drive competition and trigger innovation.

National Insurance, New India Assurance, Oriental Insurance and United India Insurance are the four State-owned insurers, besides the General Insurance Corporation of India, the national reinsurer. This reform, coupled with the hike in foreign direct investment in insurance to 74%, will allow more investments into India (including from private equity funds), make the operations of these insurers more efficient, with better managerial skills, and help foster a vibrant insurance market that can attract long-term funds.

Enforcing the same rules to bring in capital as their peers in the private sector is welcome. These insurers, other than New India Assurance, have slipped, due to deficient governance and poor underwriting discipline. Legacy issues — the erstwhile third-party motor pool, an arrangement where general insurers shared motor claims according to their market, whether or not they wrote motor business — hamstrung these insurers. Their solvency margin — the excess of assets over liabilities that an insurer maintains as a prudential measure in the interest of policyholders — is not comfortable. The government cannot keep infusing capital to shore up their solvency margin. Greater private participation will help and increase their underwriting capacity. These insurers need to improve the underwriting discipline and base their pricing on the assessment of risks, even as competition drives up general insurance penetration above its pitiable level of 1% of GDP.

TOP

Non-life insurers' premium up 19.46% at Rs 20,000 crore in July - Business Standard – 12th August 2021

Non-life insurers, which include general, standalone, and specialised public-sector, have recorded 19.46-per cent year-on-year (YoY) growth in premiums in July. In July, non-life insurers — 33 in total — earned premiums to the tune of Rs 20,171.15 crore, against Rs 16,885 crore in the same month last year. On a year-to-date (YTD) basis (April-July), insurers saw their premiums go up 15.49 per cent to Rs 64,607.25 crore, against Rs 55,939.85 crore in the same period last year. General insurers, who cover risks emanating from a whole host of segments, such as motor, health, crop, fire, marine, and others, reported 17.61-per cent YoY growth in premiums in the reporting month to Rs 16,469.20 crore versus Rs 14,003.81 crore. Further, on a YTD basis, premiums earned by them surged 12.9 per cent to Rs 56,280.58 crore. On the other hand, standalone health insurers have reported 27.49-per cent YoY growth in premiums in July over the same period last year, driven by robust demand for health products during the pandemic.

In the first quarter (Q1) of 2021-22 (FY22), health insurance premiums grew 3-per cent YoY to Rs 17,497 crore, with retail health growing at 33 per cent, and group health at 23 per cent. On a YTD basis, standalone health insurers saw their premium pool rise 46.11 per cent to Rs 5,975.52, against Rs 4,089.81 crore in the same period last year.

Notwithstanding the handsome growth in the health segment, both general and standalone health insurers have seen their loss ratios get impacted due to the abnormal rise in Covid-related claims in Q1FY22 because of the second wave of the pandemic. Insurers received over 1 million Covid-related claims in Q1FY22, higher than in 2020-21 (FY21), indicating the severity of the second wave.

According to the General Insurance Council data, general and standalone health insurers have received 1.22 million Covid-related claims so far in FY22 and have settled 944,573 of those worth Rs 9,178 crore. In comparison, they had received 986,366 Covid claims in FY21 and settled 849,034. In FY21, they paid out claims to the tune of Rs 7,833 crore, taking the total payout in two years to Rs 17,011 crore. The specialised public-sector insurers also saw robust 29-per cent YoY growth in premiums in July to Rs 1,949 crore. And, on a YTD basis, their premiums were up 17.19 per cent to Rs 2,351.15 crore.

Experts believe non-life premiums are expected to be driven by continued uptick in the health segment. Further, enhanced digital solutions, complemented by offline offerings, are expected to drive premium growth of non-life companies. Meanwhile, the loss ratio could go up, given the resurgence in Covid claims, thereby impacting financials.

(The writer is Subrata Panda.)

TOP

Parliament passes bill for privatisation of state-run general insurance companies – Financial Express - 11th August 2021

A bill to allow privatisation of state-run general insurance companies received parliamentary assent on Wednesday after the Rajya Sabha passed it with a voice vote amid vociferous protest and tearing of papers by opposition parties. The General Insurance Business (Nationalisation) Amendment Bill, 2021, was passed by a voice vote in the din in a matter of minutes, with Finance Minister Nirmala Sitharaman not replying to brief points raised by MPs.

Opposition parties from the TMC and the DMK to the Left parties opposed the bill and wanted it to be referred to a select committee but the motion was rejected by a voice vote leading to slogan-shouting by

opposition members who stormed into the Well, tore papers and moved dangerously close to the presiding officer's chair. Rajya Sabha personnel were deployed around the presiding officer and the house table to prevent a repeat of Tuesday's ugly scenes when some MPs had climbed on the table.

The General Insurance Business (Nationalisation) Amendment Bill, 2021, was passed by the Lok Sabha on August 2.

TOP

Opposition adamant on demand to send General Insurance Bill to Select Committee - The Hindu Business Line – 11th August 2021

The Rajya Sabha witnessed repeated adjournments till the evening on Tuesday and got adjourned for the day at 4 pm over the Pegasus spyware issue. The Centre's attempts to get the two Appropriation Bills and the General Insurance Business (Nationalisation) Bill amid the ruckus did not succeed as the Opposition demanded that the Bill to privatise the General Insurance Company must be sent to a Select Committee of Rajya Sabha.

As the disruptions continued, Deputy Chairman Harivansh invited the floor leaders of various parties for a discussion so that the Bills listed for the day could be taken up amid the din. "We got support of even YSRCP for our demand to send the GIBN Bill to Select Committee," an Opposition member told BusinessLine after the meeting. As Opposition remained adamant, the House was adjourned for the day at 4 pm. There are indications that the Centre will push the Bills again on Wednesday.

The Opposition members argued in the meeting that the Bill will have deep impact on the insurance sector in the country and the workers engaged with the General Insurance Company. They said the Bill demands serious scrutiny of Parliament and it should be sent to a Select Committee of Rajya Sabha.

Calling attention motion

Earlier, Opposition members protested against Chairman Venkaiah Naidu's decision to convert a calling attention motion on the farmers' protests and the three farm laws into a short-duration discussion on the problems in the agriculture sector.

Citing earlier Rulings given by Chairpersons of the House, senior Congress MP Jairam Ramesh said the ruling of the Chair on December 3, 2015 makes it clear that a calling attention motion can be converted into a short-duration discussion only after taking a complete sense of the House.

"No sense of the House was taken. This is unilateral and not acceptable," he said and added that the notice was to discuss the repealing of the three farm laws.

"On July 23, I had given the notice for calling attention motion on the three black farm laws and the ongoing farmers' agitation for the last 9-10 months. Today, I find my name shown against the short-duration discussion. My calling attention motion has been converted into a short-duration discussion on general topic agriculture problem and situation," he said.

Parliamentary Affairs Minister Pralhad Joshi said sense of the House can be taken before the discussion and requested Vice-Chairman Bhuvaneshwar Kalita to allow the debate on the issues in agriculture. "This is the decision of the Chairman, so I cannot go back and we are taking up the discussion," Kalita said. The Opposition members, however, continued raising slogans and some of the members stormed into the Well of the House.

TOP

India: Govt urged to consider requiring state transport firms to insure their buses – Asia Insurance Review

The Supreme Court has asked the government to consider withdrawing the exemption from insurance granted to 150,000 buses owned by state road transport corporations (SRTCs) because victims in accidents involving these buses wait for years to receive compensation from the government-run corporations. Compensation is withheld for long periods of time because most SRTCs operate at a loss. The Union ministry of transport and highways has said that 49 of the 56 SRTUs suffered losses, reported Times of India.

During a hearing on the issue last week, the Court said, "The vehicles of the SRTCs are not insured because of the exemption provided."

The bench of judges added that there have been many instances where the buses had to be attached for coercive recovery from the SRTUs to make payment to the claimants. The court asked additional solicitor general (ASG) Jayant Sud to examine the possibility of either withdrawing the exemption from insurance or devising a mechanism to ensure that sufficient funds are available in the SRTUs to meet their liabilities in motor accidents involving their buses.

TOP

Parliament passes Deposit Insurance and Credit Guarantee Corporation amendment bill - The Economic Times - 9th August 2021

The Lok Sabha on Monday passed a bill that seeks to ensure that account holders will get up to Rs 5 lakh within 90 days of the RBI imposing moratorium on their banks from the Deposit Insurance and Credit Guarantee Corporation (DICGC). The Deposit Insurance and Credit Guarantee Corporation (Amendment) Bill, 2021 was passed by a voice vote amid an uproar by Opposition parties over various issues, including the Pegasus snooping row and farm laws.

The Rajya Sabha passed the bill last week.

Finance Minister Nirmala Sitharaman, in her brief statement, said the legislation will benefit small depositors, including those of the Punjab and Maharashtra Cooperative (PMC) Bank. The benefits will also accrue to the depositors of 23 cooperative banks, which are in financial stress and on which the Reserve Bank of India (RBI) has imposed certain restrictions, she said.

Sitharaman said the interest of the small depositors will have to be kept in mind, adding that Prime Minister Narendra Modi has increased the insurance amount for them from Rs 1 lakh to Rs 5 lakh and within 90 days of moratorium being declared on a bank and also for those who are already under stress, the money will be available.

Once the bill becomes law, it will provide immediate relief to lakhs of depositors, whose money is parked in stressed lenders such as the PMC Bank and other small cooperative banks.

According to the current provisions, the deposit insurance of up to Rs 5 lakh comes into play when the licence of a bank is cancelled and the liquidation process starts.

DICGC, a wholly-owned subsidiary of the RBI, provides an insurance cover on bank deposits.

At present, it takes 8-10 years for the depositors of a stressed bank to get their insured money and other claims.

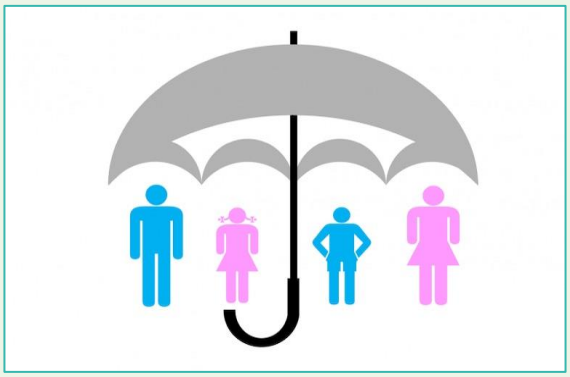
Though the RBI and the Centre keep monitoring the health of all banks, there have been numerous recent cases of banks, especially cooperative banks, being unable to fulfil their obligations towards the depositors due to the imposition of a moratorium by the RBI.

Last year, the government increased the insurance cover on deposits by five times to Rs 5 lakh. The enhanced deposit insurance cover of Rs 5 lakh came into effect from February 4, 2020.

In September 2019, the RBI superseded the board of the PMC Bank and imposed various regulatory restrictions after financial irregularities came to light.

TOP

What should family members do with a deceased person's health, car and home insurance policies? – Money control – 9th August 2021



The enormous grief apart, families are often saddled with the task of completing cumbersome paperwork after the loss of a loved one. Filing life insurance claims often figures right at the top of families' priority lists, but some other policies – such as home, vehicle or health insurance – do not get equal attention. Yet, it is important to complete the process of transferring these policies to eliminate procedural hiccups in future.

Health insurance

Many families are covered under a single health insurance floater cover. Unlike individual health policies, these insure multiple immediate family members under a single policy, up to the chosen sum insured. So, what happens to the policy if the main policyholder – the proposer – were to pass away? To start with, the surviving family members will have to inform the insurer about the incident and get the coverage details modified. "In a family floater policy, the policy will be corrected for balance members, so that future renewal notice is appropriately generated. Based on application from insured's family members, the insurer will refund the premium for the unexpired policy period as per policy terms and condition, provided no claim has been filed under the policy for the deceased member," explains TA Ramalingam, Chief Technical Officer, Bajaj Allianz General Insurance.

Therefore, the existing sum insured will remain intact – it will continue to cover the remaining members who are insured under the policy. "The insurance company will remove the proposer from the coverage and make another member of the family the new proposer in its record," adds Ankit Agrawal, CEO and Co-founder, InsuranceDekho, an insurance aggregator firm. In the case of individual health policies, the coverage ends with the demise of the policyholder – any unpaid hospitalisation claim amount will be paid to the nominees.

Home insurance

If a policyholder who is the sole owner of her house were to die, the home insurance cover attached to it, too, will have to be transferred to the new owner – the legal heir. "For instance, the spouse can send a written request to the insurance company to approve the transfer. However, whether or not to honour such a request is at the discretion of the insurance company," points out Agrawal.

So, as step one, the spouse or other legal heirs will have to intimate the insurance company about the policyholder's death and initiate the process of transfer. However, this will only be an interim arrangement. "These steps will help the spouse to keep the existing policy in place until the policy expiration date. Ultimately, the spouse will need to get a new insurance policy, once the validity period of the existing policy expires," explains Ramalingam.

There is also a provision for dealing with claims that may crop up before the transfer process is completed. "If a claim happens before the process of transfer is completed, the claim would be paid to the

nominee or legal heirs of the policyholder," says Mahavir Chopra, Founder, Beshak.org, an insurance awareness platform.

The standardised Bharat Griha Raksha policy, which all general insurers have to offer, provides a nomination facility to ensure quicker claim settlement. "However, this nomination facility is applicable only for any pending claims. That is, in case of the unfortunate death of the policyholder before receiving the claim amount, the insurance company will pay it to the nominee. If there was no nomination, then the claimants will have to submit the legal heir certificate to the insurance company," says Ramalingam.

Unlike individual health policies, motor insurance policies will not lapse immediately after the sole holder's death. "It will remain valid for three months from the date of the insured's death or until the expiry of the policy, whichever is earlier. During this period, the insured's legal heirs to whom the custody and use of the insured vehicle is passed, may apply for motor insurance policy to be transferred to the heirs or obtain a new insurance policy," says Ramalingam. You will need to submit the policyholder's death certificate, proof of title to the car and the original policy documents.

A crucial aspect in the case of motor insurance is the no-claim bonus that accrues every claim-free year. Once the custody of the deceased policyholder's car is passed on to her spouse, children or parents, the NCB, too, will be transferred to that person. "Ownership of the policy as well as of the vehicle needs to be changed after the unfortunate death of the policyholder. If, following the death of the policyholder, the insured vehicle is sold, then the insurance policy and RC book are required to be updated with the name of the new owner to complete its sales," adds Agrawal.

(The writer is Preeti Kulkarni.)

TOP

General Insurance PSUs never got the attention of the govt it needed – The Times of India – 7th August 2021

There was one day strike in the three Public Sector General Insurance companies on Wednesday. A day before Lok Sabha passed the General Insurance Business (Nationalization) Amendment Bill 2021.

The amendment, most importantly, omits section 10B of the original 1972 Act, permitting the Govt shade its stakes to any extent it deemed fit below 51%. This, technically put, empowers the Govt to forgo and sell its stake to the extent it wishes or even sell them totally to private hands.

The finance minister, however, clearly and categorically assured the house that 'what Govt is trying to do is not privatize but enabling provisions so that Govt could bring in public participation'. Finance minister felt that public participation would raise the finance of the companies to the desired levels, which in turn will help enhance insurance penetration, protect the interests of policy holders in a greater way and also help in further growth of economy.

Insurance remains one of the vital enabling factors in economic growth as also one of the important indicators of social well-being, prosperity and above all safety and security. Unfortunately, insurance sector in our country has never got the required attention and response of the successive Govt and it always remained lost somewhere in back seat. The govt response towards the sector's reforms, growth and consolidation has been casual, slow lukewarm and at times ignorant.

In Nationalization Act 1972 itself the creation of four identical companies, with the basic idea of competition among them within the stringent tariff regime was an ill-conceived and flawed idea which attracted the criticism of experts at that time and all trade unions and associations, since inception, demanded a merger of all the four companies into a single monolithic entity in line with LIC of India. Govt never even gave a serious thought to the idea.

Post opening up the sector with the advent of a regulator, Insurance Regulatory & Development Authority (IRDAI), the regulator often drifted from its mission and did too little to either 'regulate' or 'develop' the sector. It allowed the companies, private as well as public, to practice unhealthiest of competition with practically no functional control. This unhealthy competition enabled newly formed private players to thrive – as they had no base, thus no expenses and could invest enormously – and made the established PSUs – who had broad net-work and therefore huge management costs – sick to proceed to a slow inevitable death.

There were, in place, IRDAI's own strict guidelines calling to bring about 'optimum amount of self-regulation in day-to-day working' of the industry and there were also provisions 'to take action where such standards are inadequate or ineffectively enforced', But that remained on the paper. In the name of competition, for example, companies were allowed to grant abnormally and ridiculously high discounts of 99.99% as a regular practice over guide rates of premium, till very recently when these discounts have been now caped but this happened only after the PSU companies became almost unsustainable requiring urgent govt intervention in terms of financial assistance.

For years together IRDAI went on either not doing anything to exercise 'control' or going on doing the things grossly detrimental to the working of PSU companies. It would never be known whether the regulator did all these deliberately or simply suffered from typical bureaucratic mentality.

In 2018-19 budget govt decided to merge these companies into one entity by 2019-20. The govt appointed consultants to study and recommend precise modalities and procedure of merger. Companies were advised to prepare for the merger and proceed for the formalities needed therefor. Boards of all the companies, accordingly, passed resolutions for the merger and were proceeding ahead with the active preparations in terms of govt detailed guidelines. The merged company was envisaged to become the largest general insurer of the country.

In 2020 govt decided to infuse Rs 12450 Crores in these companies and also raised the authorized share capital of National Insurance to 7500 Crores and of Oriental Insurance and United India Insurance to 5000 Crores each. A further amount of 6950 Crores was committed to be infused in 2020-21 budget as well. While all these preparations were taking shape, in a sudden U-turn in the middle of 2020-21 the govt decided to abort the merger plan altogether providing no clue at all as to what led to this decision and/or what was the further roadmap for the ailing PSUs.

These uncertainties and lack of any focused direction led these companies to further operational deterioration and crippling financial results year after year. Operating losses continued to soar and the Solvency Margin – as derived for the ratio of liabilities over assets – remained critically lower than the regulator's stipulated limit of 1.5. During 2019-20 the three companies together posted a large net loss of 7118 Crores as at the end of 2019-20.

During 2021-22 budget the finance minister announced plan to privatize two PSU banks and one PSU general insurer requiring legislative amendments. With the current amendment, however, the Govt has armed itself with the power to tweak any or all of the three PSU insurers the way Govt may feel suitable. The logic and equity of the decision privatizing one of the insurers appears beyond any sound comprehension. Why the one will be singled out and how? Whether the other two would follow? What would be, after all, the fate of the two remaining PSU insurers?

The Govt, of course, is not expected to go on infusing huge capital year after year to run these insurance companies when they are not able to stand on their feet. But there has to be a definitive strategy and a focused path to proceed to. The Govt decided that there would be one to four PSUs in all the 'strategic sectors' to be decided by the govt. Insurance sector has since been decided to be a strategic sector. With New India Assurance already being a listed company, with another one to be privatized and with this current amendment to the Nationalization Act of 1972 empowering the Govt to reduce its stakes below 51%, which company in general insurance sector is going to be a PSU? Even the LIC of India, the only PSU

in life sector, is supposed to go to public with its shares. Does that imply that there will not be any PSU working in insurance sector, a sector termed as 'strategic' by the Govt itself?

Insurance is a sensitive sector for the economy and the Govt has rightly placed in the category of strategic sector. But the intent of the Govt towards this is seemingly confusing and non-serious. A merged company coming out of the three with little hand-holding would have definitely come out of crisis and would have proved to be a formidable entity. Not going with that and instead empowering itself shedding its stakes raises serious doubts about the intentions of the govt. Otherwise why there would not be plan for PSU – one each of life and general sectors – despite Govt terming insurance one of the strategic sectors?

It has been proved beyond doubt that PSUs, at least in financial sector, have the unquestionable capabilities of combatting any competition and striving well. The State Bank of India in banking sector, the Life Insurance Corporation of India in life insurance sector and the New India Assurance in general insurance sector have proved it decisively. When LIC of India's survival as a PSU is clearly compromised by the Govt, the intent of the Govt about PSU general insurers can just be guessed. Nevertheless, the is need of the hour is a clear motive, a smooth roadmap and a definitive time- line. We still have the time for this.

TOP

HEALTH INSURANCE

Govt to absorb health innovation cost in 23,000 hospitals under Ayushman Bharat – Live Mint - 12th August 2021

The National Health Authority (NHA), implementing agency of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) has planned to absorb health innovation costs in over 23,000 hospitals empanelled under the scheme to mitigate covid-19 pandemic.

Recognising the role of innovations to strengthen India's response to the covid-19 crisis and preparedness for emerging healthcare needs, NHA on Thursday signed a Memorandum of Understanding (MoU) with Indian Institute of Technology Delhi (IIT Delhi). Through this partnership, NHA will be a technical collaborator of the US Agency for International Development (USAID)-supported SAMRIDH Healthcare Blended Financing Facility. IIT Delhi serves as the hosting entity for SAMRIDH.

SAMRIDH Healthcare Blended Financing Facility aims to catalyse market-based health solutions to improve access to affordable and quality healthcare services for low-income and vulnerable communities, particularly for AB PMJAY beneficiaries. SAMRIDH has mobilised a capital pool of $100 plus million from private sector and development funders. It leverages this fund to offer both grant and debt financing provision to healthcare enterprises and innovators. "SAMRIDH will provide a platform to facilitate affordable capital for scaling up of commercially viable innovations. The facility will also extend mentorship to enterprises from clinical, technology and business experts," said V. Ramgopal Rao, director, IIT Delhi.

Through this partnership, NHA and IIT Delhi will support innovative solutions to address the needs and priorities of the AB PMJAY ecosystem. This collaboration will be crucial to support rapid scaling and absorption of health innovations across more than 23,000 AB-PMJAY empanelled hospitals. This partnership, leveraging distinct sources to identify innovative healthcare solutions, will provide a platform for diverse set of organisations, including manufacturers/suppliers of drugs, vaccines and health-tech, private healthcare networks, innovation incubators, social enterprises/NGOs, research and

academic institutions, to come together towards solving complex healthcare challenges in India. A total of 3, 27,672 covid-19 hospital admissions have been authorized under Ayushman Bharat in 2020-21 with a cost of ₹1157.66 crore, according to the union health ministry.

The allocation of funds under AB-PMJAY is integrated both for covid-19 and non-covid-19 treatments. Funds are released as per requirement of states and union territories. About Rs1157.66 crore was authorised for covid treatment in FY21, the government told the Lok Sabha recently. India reported over 41,195 daily new coronavirus infections over the last 24 hours and 491 death. Active cases were at at 3, 87,987, making for 1.21% of total cases, which is the lowest since March 2020. Daily positivity rate stands at 1.94%. The rate has remained below 3% for the last 17 days and below 5% for 66 consecutive days now.

"India's recovery rate currently stands at 97.45%. This is the highest ever recovery rate achieved by India since the start of the pandemic," the union health ministry said in a statement.

(The writer is Neetu Chandra Sharma.)

TOP

Is treatment for mental health covered by insurance policies? – Live Mint – 12th August 2021

There has been a substantial rise in mental health issues due to the covid-19 pandemic. Depression and anxiety lead to such problems.

While many people rushed to buy health policies to handle the challenges and meet the sudden rise in medical costs, it is increasingly essential for them to also check whether the insurance policies cover mental health issues.

Ankit Agrawal, chief executive officer and co-founder, InsuranceDekho, said, "For a long time, health insurance policies didn't cover mental illnesses in India. But fortunately, we are now seeing a shift in the trend. Some time back, all health insurance companies were only covering physical health issues and disorders. But now, a few are offering cover for psychological disorders as well."

If we go by the definition of mental illness, there are two explicit exclusions in them. First, the policies would not cover mental retardation. Second, they would also exclude outcomes due to abuse of drugs or alcohol.

The shift has been in line with directions of the Insurance Regulatory and Development Authority of India (Irdai). The insurance regulator had asked health insurance companies to add mental illnesses to all regular health insurance coverage. Also, it has told them not to deny health insurance coverage to policy buyers who have used antidepressants or opioids in the past.

"Adhering to the guidelines of Irdai, some insurers offering health insurance plans have already started customizing their products to include cover for mental illnesses. Max Bupa Health Insurance, ICICI Lombard, Aditya Birla Health Insurance Company, HDFC Ergo General Insurance and Digit General Insurance are a few popular insurers that have introduced health insurance policies specifically designed to cover people suffering from mental illnesses. Generally, health insurance plans offered by these insurers cover in-patient hospitalization expenses for mental illness. But outpatient counselling or therapy is covered only if the policy offers outpatient department (OPD) benefits," said Agrawal.

What you should do: So, suppose you are looking for a health insurance policy with cover for mental illnesses, you must check if the disorder requires hospitalization or therapy, and whether medication

would be adequate to treat it. In the former case, you must choose a comprehensive indemnity policy that covers hospitalization. While in the case of the latter, you must go for a policy that covers OPD. The importance of cover for mental health treatment in health insurance has gained significant attention, especially during the covid-19 pandemic.

“Apart from several other issues, the pandemic led to a rise in poverty and unemployment, too, both of which are associated with a higher incidence of mental health issues. And these health issues, if not treated well in time, may worsen the situation in many cases," said Agrawal.

“Apart from their severity, the treatment for mental health issues can be hard on the pocket, and not everyone may be able to afford the same. This is why, when choosing a health insurance company, it is important to go with the one that offers adequate cover for mental health issues and related expenses under its health insurance plans," said Agrawal.

(The writer is Navneet Dubey.)

TOP

Should you get a hospital OPD insurance? – Live Mint – 10th August 2021

While health insurance compensates you for your hospitalization expenses in the case of extreme health conditions, it may not pay you for regular check-ups or appointments with your doctor. In such a situation, should you go for a health insurance policy that can cover outpatient department (OPD)-related expenses?

Generally, OPD treatments require frequent visits to hospitals as it includes treatment for ailments, regular health check-ups, or follow-up for ongoing medication.

While taking OPD treatment, patients are not required to be hospitalized but can visit any associated facility in the hospital. All this results in hefty reimbursement bills for an insurance company; hence mostly OPD coverage is not part of a health insurance policy.

Moreover, day-care procedures, inpatient treatment and naturopathy treatments are not covered under OPD expenses. Besides, cosmetic treatments and self-inflicted injuries are also not covered. Purchase options: OPD coverage is part of a base regular health policy, and it can be bought as a separate rider, too.

Most health insurers offer coverage for inpatient, day-care hospitalizations and inpatient hospitalization claims when you look closely. In maximum cases, the policyholder gets OPD benefits such as medicines, consultations and diagnostic tests under pre-hospitalization, that is, 30-90 days and post-hospitalization, that is, 60-180 days. The policyholder can also get a separate defined OPD limit apart from the OPD being covered under inpatient and pre- and post-hospitalizations cover, provided that the regular health policy has in-built OPD coverage available.

Rakesh Goyal, director, Probus Insurance, said, “There are health insurance policies that offer the OPD cover as an add-on cover. However, for this, they do charge some extra premium. This add-on cover would include secondary treatment costs, that is, if the insured is not admitted into the hospital as a daycare patient and comes as a valuable purchase for people who tend to visit the hospital frequently."

Benefits: Health insurance policies that include OPD coverage benefit policyholders in the following ways: It is beneficial for patients who require frequent hospital visits for OPD consultations. The insured may be reimbursed for large pharmacy bills. OPD coverage is extremely beneficial for patients with pre-existing medical conditions that necessitate frequent medical consultations. Immuno-compromised people may also benefit from OPD health insurance. People with chronic medical conditions such as asthma, diabetes, arthritis, thyroid disease and others who require regular doctor consultations can benefit from OPD coverage.

Amit Chhabra, head - health and travel insurance, Policybazaar.com, said OPD coverage is available via a variety of individual health policies. “The sum assured in the majority of these plans ranges between ₹5,000 and ₹20,000, but there are some that go much higher. Some policies include sub-limits in the OPD sum assured for specific treatments such as physiotherapy," Chhabra added.

Reasons to buy OPD cover: Anyone can buy OPD health insurance cover. But it can be only beneficial for patients who are undergoing treatment that requires regular or frequent OPD visits. However, you must also understand that the terms and conditions of OPD treatment vary from policy to policy and from insurer to insurer. For instance, some policies may provide cover for vaccinations, while others may restrict you from using specific chemists.

Goel said, “It is not suggested to include OPD cover in a health insurance policy, as OPD requires a limited cost involvement which a policyholder can easily afford. However, in case a person has any pre-existing disease, which demands a regular doctor consultation, suffering from chronic diseases, having low immunity, and higher prone to vector-borne diseases, then a policyholder can opt for an OPD cover to get financial support from his regular health insurance."

However, the premiums of policies covering OPD treatment are a bit higher compared with those that do not cover. For instance, you may have to pay an additional ₹5,000 to 8,000 to get an OPD cover of ₹10,000-15,000 sum insured. Besides, the OPD cover comes with a deductible. Hence, given that the covers are usually priced at 70-80% of the maximum claim, and the claim process can be cumbersome, getting an OPD cover may not be very valuable.

“Since OPD charges fall on a high side of cost and are frequent, OPD coverage makes a health insurance plan relatively expensive. While a normal health insurance policy premium comes around ₹12,000 at best, the same policy would come for ₹48,000 for ₹50,000 OPD coverage," said Goel. He added that although the OPD cover comes with a set of valuable benefits, one must understand that the price of such coverage might be on the higher end compared with the regular health policy premium. Hence, one must analyse self and the family usage of primary healthcare to figure out whether this plan is beneficial or not.

(The writer is Navneet Dubey.)

TOP

Covid health claims of Rs 10,703 cr pending before insurers despite HC, Irdai directive - The Indian Express – 9th August 2021

With insurance claims going through the roof amid the Covid-19 pandemic, insurance companies are sitting on almost one-third of the claims submitted by patients since the pandemic hit the country in the beginning of the financial year 2020-21. Over 3.06 lakh Covid claims for Rs 10,703 crore are pending before insurance companies as on August 6, indicating the pressure being faced by insurers despite Delhi High Court and insurance regulator IRDAI directing the insurance firms to complete the settlement of Covid claims in an hour after discharge.

Health insurance companies have received a total of 23.06 lakh claims worth Rs 29,341 crore as on August 6, 2021, according to figures compiled by the General Insurance Council. However, insurance firms have settled only Rs 17,813 crore involving 18.99 claims so far.

Of the total claims, 13.19 lakh claims worth Rs 14,783 crore came between April 1 and August 6, 2021 during the financial year 2021-22 while 9.86 lakh claims for Rs 14,560 crore were reported during the financial year ended March 2021.

According to insurers, the sharp rise in Covid claims has hit them substantially. "Yes, health claims have gone up a lot. While the number of claims went up, the average cost of a covid claim is twice the size of non-covid claims. Thus, the hit has been substantial," said Kamesh Goyal, Chairman, and Digit Insurance. The big rise in claims even forced some insurance companies to stop issuing health policies for some periods. Many companies were even forced to go slow on issuing term policies as death claims also shot up. "I'm sitting on a 400 per cent loss in Covid claims," said the regional manager of a public sector insurer.

The General Insurance Council, the representative body of 34 general insurers in the country, has laid down a basic framework for seeking the cooperation from hospitals to implement the directives. It has asked hospitals to submit all the patient discharge documents in one go without having to be reminded of the missing documents like cashless treatment approval reference, copy of the case sheet, prescriptions, diagnostic reports, bills, discharge summary, Covid positive and the subsequent Covid negative reports. They were also advised to ensure billing done at pre-agreed rates and provide justification with supporting medical records for any co-morbidities necessarily treated.

According to the Council, when the patient's progress is good and discharge is planned for the next day, hospitals should inform the insurance company or TPA of the impending discharge the soonest and submit the available documents and bills. "Balance documents and bills pertaining to the last 24 hours could be submitted at the discharge time so that the insurance company or TPA could also start working on the discharge simultaneously," it had said.

Currently, insurers take up to five or six hours for settlement of hospital claims and patients are held up in the hospital during this period. Hospitals refuse to discharge patients without getting the insurer's approval.

Earlier, the IRDAI had asked all general and health insurance companies to communicate their decision on the authorisation of cashless treatment for Covid-related claims to network providers within an hour of receiving the request. Also, they have to communicate their decision on the final discharge of patients, whose Covid claims are covered, within an hour of receiving the final bill from the hospital.

On the rise in hospitalisation costs, Goyal said, "medical inflation is real, 8 per cent in May 2021, compared to 6 per cent in Jan 2021. So yes, hospitalization costs will increase. The idea here is to have sustainable and valuable products and also make people aware of the right sum insured they should be looking at keeping the rising expenditures in mind. We also need to keep in mind that Covid has led to some billing for PPE, gloves etc which was not there before." Meanwhile, insurers rejected 41,763 claims worth Rs 361 crore in 2020-21 and 58,920 claims worth Rs 464 crore up to August 6 in 2021-21.

(The writer is George Mathew.)

TOP

Ayushman Bharat scheme uptake low for Covid-19 as states make treatment free - The Economic Times – 7th August 2021

With many states making Covid-19 treatment free of cost, the uptake from Ayushman Bharat national insurance scheme was quite low in private hospitals, just over 3,45,000 until July compared to a national case load of 31.53 million. Andhra Pradesh accounted for the highest uptake with 1,17,937 beneficiaries using the scheme for Covid-19 treatment, while it went down as low as four in the case of Bihar and 164 for Uttar Pradesh. This information was obtained by ET under the RTI Act, which the National Health Authority later updated, while furnishing its response.

(The writer is Nidhi Sharma.)

TOP

Does group insurance cover pre-existing diseases? – Live Mint - 7th August 2021

Most health insurance policies do not cover any pre-existing diseases (PEDs). However, when buying a new health policy, it is vital to understand whether group health policies cover PEDs.

Generally, if policy buyers have PEDs, they are required to undergo several procedures. PEDs entail higher financial risk for insurers. So, insurers may not cover these diseases in the initial years when buying a health policy. Therefore, it helps, if you look at particular health policies covering PED in health insurance.

A pre-existing disease or PED refers to the medical condition that a person already suffers from before the policy purchase. These may include diabetes, hypertension, asthma, among others. The exclusion of these PEDs is a matter of concern for those who are looking for comprehensive health insurance cover from day one.

Retail health policies don't cover PEDs

Mayank Kale, CEO, and co-founder of Loop Health said, "Historically, insurance companies have seen a lot of fraud in retail policies, so they have tightened up what is covered. There's an adverse selection problem with buyers. This means that they don't cover PEDs for 3-4 years when individuals buy retail policies."

However, group health insurance policies cover PEDs since, in this case, a company is buying the policy and not an individual; there is a lower risk of fraud, so PEDs are included. And, companies have been demanding more coverage in their health benefits.

Indraneel Chatterjee, RenewBuy said that group insurance policies cover PEDs. Majority of companies that provide health insurance policies include this coverage as part of their standard health policy. The employee, their spouse, dependent parents, and dependent children up to a certain age can all avail benefits of PED in group insurance plans. Group insurance premium depends on five factors—group size, employee age factor, parents' cover, maternity cover, and PED cover from day one.

"The terms and conditions, inclusions as well as exclusions are same for every individual covered by the policy. There is no need to declare pre-existing conditions and no waiting period in case of group health cover if the company chooses the option while paying the premium," said Chatterjee.

Is PED coverage enough?

Group health cover offered by employers is a perquisite that the employer can discontinue at any time. Further, the health coverage is linked to your job or service tenure. Once you quit the job, the policy gets terminated. Moreover, unlike retail health policies, a group policy cannot be extended or renewed further. Hence, one should look at PED coverage, and other terms and conditions need to be evaluated while calculating one's health insurance need. Ideally, it would be paramount to go for additional coverage that can effectively plug the gaps in the group health policy without unnecessary duplication of coverage.

"You should not completely rely on group health policy. HRs are asking for more comprehensive benefits, including OPD, paediatrics, maternity, mental health counselling, and other services. These are not covered by default in group policies and can be expensive! However, the pandemic has driven companies to provide better health benefits that people can really use," says Kale.

(The writer is Navneet Dubey.)

TOP

Exhausted your health insurance sum insured? Replenish it with the restoration benefit – Money control - 7th August 2021

The second wave of COVID-19 in India is slowing down, but the nightmare is still not over yet. Of the fortunate ones who survived the infection, many started showing signs of post-COVID complications. Common neurological problems such as fatigue, brain fogging, and stroke were seen in many people. To add to this series of unfortunate incidents, the threat of a third wave has already started emerging.

Owing to this, it seems as though people have become more cautious of the importance of having health cover to protect themselves and their families. But, considering the rising healthcare costs and multiple hospitalizations due to COVID-19, it is quite possible that the entire sum insured gets exhausted in a single hospitalization. This is when 'restore benefit' in a health insurance feature comes in. Restoration benefit provides you with additional coverage in case you use up your existing cover in any given policy year. This is an in-built feature available in almost every comprehensive medical plan.

How does it work?

The restoration benefit, as the name suggests, restores the entire sum-insured after the initial sum insured is completely or partially exhausted in the same policy year. For instance, let's say Rajesh buys a family floater plan with a cover of Rs 5 lakh for his family of four. He undergoes an open-heart surgery which consumes his whole sum insured. After two months, his daughter also gets hospitalized for another ailment that resulted in a medical expense of Rs 3 lakh. Now, here, the restoration benefit comes into action. It automatically reinstates the full amount of sum insured on exhaustion of his cover. Thus, the restored benefit works as a magical backup as the entire sum insured is replenished for the policyholders, keeping them financially protected at all times.

There are two types of restoration options and are categorized according to the consumption of sum insured. Under complete utilization of the cover, the benefit comes into play when the entire sum insured is exhausted. Some companies, however, offer restoration benefits on partial consumption of the sum insured. The benefit comes into play even if the sum insured is partially exhausted.

Who should opt for a restoration benefit?

The restoration plan is best-suited for people with Family Floater policies. This plan is shared among family members. In such plans, this feature ensures that all the members of the family are adequately covered by the insured sum. For instance, if one of the family members uses up the whole coverage, the restored sum insured will guarantee that the policy covers the medical costs of other family members.

Also, people who cannot afford higher sum insured policies must look for restoration benefit in their health insurance plans. This feature will help you reduce your out of pocket expenses in case of an emergency.

Keep in mind the following conditions related to restoration benefit

Restoration benefit is available only for different illnesses

To put simply, under some policies, if you use the sum insured for a specific disease such as heart attack, you cannot use the replenished sum insured for the same problem again within the same policy term. The restored sum insured can still be used by other members for the same disease. However, some policies cover even the same illness as they provide the option of reinstatement of sum insured for treatment of the same ailment during a policy year.

It works on a tenure basis

One can use the restored benefit only once in a policy year and unlike the no-claim bonus, it cannot be carried forward for the subsequent policy year, even if you did not use it in the same policy year of restoration.

Not available for the first claim

One important factor that needs attention is that the restoration benefit can only be used for future claims. So, one cannot avail this benefit on the very first claim of the policy year.

For Instance, if your hospitalisation bill comes to Rs 6 lakh and your current health cover is Rs 5 lakh, considering that it's your first claim you'll be reimbursed for your health cover amount only and the difference would be at your expense. However, if you make any subsequent claim in the same policy year, your sum-insured will be reinstated for that.

(The writer is Amit Chhabra.)

TOP

Are farmers reaping the benefit of PM Fasal Bima Yojana? - The Hindu Business Line – 9th August 2021

The Pradhan Mantri Fasal Bima Yojana (PMFBY) launched in 2016-17 is globally the largest crop insurance scheme in terms of farmer participation and the third largest in terms of the premium according to the Central government. Over 5.5 crore farmer applications are received on a year-on-year basis, and till date, the scheme has insured over 29.16 crore farmer applications. Over the period of five years, more than 8.3 crore farmer applications have benefited from the scheme. A major chunk of smaller farmers, however, still remain out of the crop insurance network. The percentage of marginal farmers in the scheme has seen a decline from 18.08 percent to 16.55 percent for Kharif between 2018 and 2020. The participation of small farmers in the scheme is between 63-68 percent. While the Central government wants to expand the scheme, farmers seem to be unhappy with its current format and execution. Farmers in Maharashtra have intensified their agitation against insurance companies implementing PMFBY, alleging that the insurance firms are hand in glove with the government and that a majority of the farmers are being deprived of the benefits of the scheme. Many farmers here are still waiting for the insurance amount for the crop damaged in 2018. It is not just the farmers in Maharashtra who are up against PMFBY and implementing companies. Their counterparts in other States have been raising similar issues too.

However, the insurance companies and the government have a different take on the scheme and its impact. The PMFBY is available for all States and farmers -- whether loanee, non-loanee, share cropper, or tenant farmers -- on a voluntary basis. The States notify the crops and areas under the scheme. One of the main aims of the scheme is to provide financial support to stabilise the income of farmers, especially in natural calamity hit seasons/years to ensure their continuance in agriculture. From 2016-17 to 2019-20 (provisional figures) 2,307.4 lakh farmers' applications have been insured under the PMFBY. Out of these applications, 772.1 lakh applications – that is 33.46 percent of applications – have benefited from the scheme, according to the data presented by the Ministry of Agriculture to the Lok Sabha on July 27, 2021. Farmers have to pay a maximum 2 percent premium for Kharif, 1.5 percent for rabi food and oilseed crops, and 5 percent for commercial/horticultural crops. The balance of actuarial/bidded premium is shared by the Central and State government on 50:50 basis (in the case of northeastern States, it is 90:10). In the four years (2016-17 to 2019-20), farmers across the States have paid ₹17,573 crore as their share of the premium that comes to 16 percent of the gross premium of ₹1, 07,449 crore. These figures include provisional figures for 2019-20 which the government is updating.

The Ministry of Agriculture told the Rajya Sabha on July 23, 2021, that all the five public sector general insurance companies and 14 private sector general insurance companies have been empanelled by the government of India for implementation of PMFBY in the country. However, the specific implementing insurance company is selected by the concerned State through a transparent bidding process. The Ministry has provided the data on claims paid by 18 insurance companies. Agriculture Insurance Company of India Limited has paid the highest claims of ₹33,491 crore in four years. This amount is about 36 percent of the total claims paid by all companies during this period. Out of the total gross premium of ₹1,07,449 crore collected by the companies in four years (2016-17 to 2019-20) about ₹92,426 crore – that is 86 percent – has been paid to farmers to settle insurance claims. The data reveals that some private insurance companies have opted out of the scheme. In 2019-20, four companies didn't participate in the scheme while Shriram General Insurance Company Ltd was part of the scheme only in 2016-17. Industry players complain that PMFBY is not benefiting their business.

In March this year, the Ministry of Agriculture told the Rajya Sabha that crop insurance is a major risk mitigation tool for the benefit of farmers. The Ministry added that the difference between premium collected and claims paid may not be the margin/profit for the insurance companies. "The cost of reinsurance and administrative cost totalling 10 percent to 12 percent of gross premium also has to be borne by the insurance companies. Further, out of the total crop insurance business under the scheme, about 50 percent is shared by the five public sector insurance companies including Agriculture Insurance Company of India Ltd." the Ministry informed. However, farmers disagree with the government's explanation. "Many of the insurance companies don't have any set up on the ground. Right from paying premiums to submitting insurance claims, farmers have to struggle a lot. The majority of the time, even helpline numbers of the companies are not working," said Prashant Pawar, an agri-entrepreneur.

Farmer leader and former MP Raju Shetty said that farmers have not been receiving insurance claims for years and they have to turn to private money lenders to recover losses and make provisions for the next cropping season. The outstanding amount is higher in Telangana followed by Jharkhand, Gujarat, Karnataka and Madhya Pradesh. Among these five States, Telangana, Karnataka and Madhya Pradesh are the regions which have witnessed the highest number of farmer suicides between 2014 -2018. Maharashtra, which has reported highest farmer suicides (12,813) during this period, has outstanding insurance claims pending from 2018. According to the Agriculture Ministry, as per provisions of PMFBY, admissible claims are generally paid by the insurance companies within two months of completion of crop cutting experiments/ harvesting period – subject to availability of yield data, subject to receipt of the total State share of premium subsidy from the concerned State government within time. "However, settlement of claims in some States get delayed due to reasons like delayed transmission of yield data; late release of their share in premium subsidy by some States, yield-related disputes between insurance companies and States, non-receipt of account details of some farmers for transfer of claims to the bank account of eligible farmers and NEFT related issues, etc.," the Ministry stated last month in the Lok Sabha.

(The writer is Radheshyam Jadhav.)

TOP

Prepare your vehicle for the upcoming monsoon season with important add-ons - The Indian Express – 6th August 2021

Every monsoon season, we encounter a plethora of problems due to waterlogging in different parts of the city. The water not only creates problems for people by restricting their movement but is also a major threat for vehicles running on the roads. With monsoon already knocking on the door, it is important that we stay prepared for any unforeseen circumstances. To make sure that your vehicle does not suffer any major damage due to waterlogging across the city, it is important that you do all major checks before taking the vehicle out. Here are a few tips that must be kept in mind this monsoon season to sail through without any issue.

Buy essential add-ons

Often while buying a motor insurance policy, people just look for the most common add-ons like Return to Invoice, Zero Depreciation, and Key and Lock Replacement Cover. While these are some important covers that make the motor insurance cover more comprehensive, there are some lesser-known add-ons as well that are actually much more important than anything else. These covers make sure that your vehicle is protected against some of the most common damages that are possible during the monsoon season. With instances of floods, waterlogging and cyclones becoming quite popular throughout the country, it is essential that you buy these covers while buying or renewing your motor insurance policy.

Roadside Assistance

One of the most essential add-ons that every vehicle owner must-have for his vehicle is Roadside Assistance, as you may never know when you might need help while driving on road. Say for instance you traveling for some important business or an office meeting or maybe just heading towards a vacation in your vehicle. Would you ever want to be stranded on the road for long hours waiting for help from family and friends? Here is when the Roadside Assistance add-on cover kicks in. This add-on makes sure that the right person reaches you for help in the minimum time possible. No matter how big or small your problem may be this add-on makes sure the right professionals are there for you whenever you need them. This add-on also comes at a nominal cost of Rs 150 – 500, depending upon the IDV of your vehicle.

Engine Protection

Yet another must-have add-on for every vehicle owner is the Engine Protection cover that protects the engine of your vehicle against any possible damages. It is important to know that a regular motor insurance policy does not cover the damages to the engine due to water. If you are out on a rainy day, chances are quite high that due to waterlogging, the water may reach some important parts of the vehicle and cause major damages. Once the engine of the vehicle is damaged, the cost of repairs may reach several lakhs. To avoid being caught in such a situation, it is advised to buy the right add-on beforehand. This add-on is a must-have insurance feature to save a substantial amount of money at a nominal premium cost of 0.15 per cent to 0.20 per cent of the Insured Declared Value (IDV).

Buy monsoon related car accessories

While add-ons play an important role in protecting your vehicle from all possible damages, it is your responsibility as well to make sure that the vehicle does not gets damaged. You must make sure that before driving on the roads, your vehicle is well equipped with the best accessories that give the utmost protection to your vehicle. Some of these accessories include headlights, wipers, mud flaps and rubber mats. All these products have their individual usages and must be bought of the best quality to ensure the best possible results.

(The writer is Utpal Raman Sharma.)

TOP

INSURANCE CASES

Insurance firm asked to pay interest on delayed payment - The Tribune – 7th August 2021

The District Consumer Disputes Redressal Commission here has directed an insurance company to pay interest on the maturity amount released to a consumer six months after due date. Shelly Dhawan, a resident of Sector 36, Chandigarh, alleged that she had obtained a policy from Bajaj Allianz Life Insurance Company Limited in the name of her minor daughter and deposited yearly premiums from 2004 to 2019.

She said the insurance company was to pay first pay-out of Rs81, 096.47 against the policy by March, 2020, but it failed to release the due amount despite repeated requests and emails. The insurance company denied all the charges, saying that they paid a net amount of Rs82,482 as first pay-out on September 14, 2020 by crediting it in the bank account furnished by the complainant and the remaining amount was to be paid on attaining the age of 19, 20 and 21 years, respectively.

The company pleaded that there was a slight delay in the payment due to the closure of the office in view of the Covid-19. After hearing the arguments, the commission noted that the complainant was entitled for the interest on the pay-out amount of Rs 82,482 for the delayed period. The commission thus directed the insurance company to pay her an interest at nine per cent per annum on the amount of Rs82, 482 from the due date to the day it is paid.

The commission further said it was not imposing any cost or compensation on the company taking a lenient view due to Covid-19 situation which hampered the payment in time. — TNS

TOP

PENSION

PPF: How to make the best of Public Provident Fund - Financial Express – 9th August 2021

The Public Provident Fund (PPF), the government-backed small savings scheme run by the Ministry of Communications, can be looked at for regular deposits. Experts say the popularity of this scheme as an investment option other than its tax benefit is because it can be started with a minimal investment amount.

Along with the safe and secure nature of this investment, the triple tax break — EEE (Exempt, Exempt, Exempt) – also lures investors to this scheme.

Even though PPF offers assured returns every year, the exact figure fluctuates. Interest on PPF is compounded annually and gets credited to the depositor's account on March 31 every year. Even though the interest is credited into the account on the last day of the financial year, it is calculated every month. Note that, interest is payable for a month only if the deposit is made before the 5th of that month. Hence, under the PPF scheme, interest is calculated every month, compounded annually, and is reset every quarter.

The catch about PPF is that it comes with a lock-in period of 15 years. The date of maturity when calculating the tenure is not calculated from the date of opening the account. It is instead calculated from the end of the financial year in which the deposit was made, irrespective of the month or date in which the account was opened, hence, it is actually 16 years.

An investor can avail deduction under Section 80C of the I-T Act, up to Rs 1.5 lakh, and need not pay tax on part of the income that equals the invested amount. Additionally, the investor also doesn't have to pay tax on the returns earned during the accumulation phase, or at the time of withdrawal.

Here is how you can get the best out of your PPF account:
Industry experts say one should use their PPF account as a retirement savings tool, or for other long-term goals such as a child's higher education, child marriage, starting a business, etc. Just aim it towards a goal, having a long-term perspective in mind.

One can invest in the account every year, from a minimum of Rs 500 to a maximum of Rs 1.5 lakh, under Section 80C. An investor with a long-term goal should deposit the maximum amount that can be deposited – Rs 1.5 lakh every year – if it fits their asset allocation and long-term goals.

If you are depositing Rs 1.5 lakh at one go, try to deposit it in the first month of the financial year, i.e., in April, and before the 5th. It may be noted that the interest is calculated on the lowest balance between the 5th and the last day of every month. So, if you put your money in the PPF account before the 5th of each month, your contribution will earn interest for that month also.

Additionally, if you are unable to put in a huge amount at one go, you could put the money in 12 instalments, wherein each requires an investment of a minimum of Rs 500 monthly. In this case, also, try your best to put your money in the PPF account before the 5th of that month.

(The writer is Priyadarshini Maji.)

TOP

PF account rule change from next month: EPF subscribers must do this or else... – Live Mint - 9th August 2021

The Employees Provident Fund (EPF) subscribers have to link their Aadhaar with the Provident Fund (PF) accounts before 1 September. Employees' Provident Fund Organization (EPFO) has made it mandatory to link Aadhaar with PF UAN (universal account number) to get PF contributions from the employers. Earlier, the deadline was 1 June which was extended to 1 September.

In a circular, the retirement fund body EPFO said that the directive on Aadhaar matching will not happen from 1 June as was announced earlier but from 1 September. It asked all its field offices to ensure that employers are ready to implement the decision from 1 September.

As per the previous direction, EPFO was insisting on validating Aadhaar, which means unless all details like name, date of birth, gender match, it was not allowing to pay the monthly EPF contributions. The move had prevented lakhs of workers especially low paid formal sector employees due to the mismatch of records.

So, If you have still not linked your Aadhaar with your PF account, then do the needful. The EPFO has also issued a notification whereby it is now the responsibility of the employer to ensure that their employees link their provident fund account to their Aadhar number. in view of the second wave of coronavirus infections in the country, EPFO had allowed its over five crore subscribers to avail of the second COVID-19 advance.

Earlier last year, the retirement fund body had allowed its members to withdraw COVID-19 advance to meet exigencies due to the pandemic. The members were allowed to withdraw three months basic wages (basic pay dearness allowance) or up to 75 per cent of the amount standing to their credit in their provident fund account, whichever is less. You will also lose out on other EPF benefits, which includes taking COVID-19 advances, insurance benefits, too if your Aadhaar details are not updated.

TOP

National Pension Scheme: Penny drop to validate NPS subscriber details – Financial Express – 9th August 2021

In order to resolve problems faced in making payments to subscribers on exit or partial withdrawal from the National Pension Scheme (NPS), the pension fund regulator has initiated Instant Bank Account Verification by 'penny drop'. It will be done by the central record keeping agencies (CRA) by integrating their information technology system and exit framework with the fin-tech service providers.

This initiative by Pension Fund Regulatory and Development Authority (PFRDA) will ensure timely credit of money and additional due diligence to identify the rightful beneficiary as there were instances when

the subscribers' withdrawal amount could not be credited into their savings bank account due to reasons such as invalid account number or account type, invalid or wrong IFSC code, name mismatch, dormant account, etc.

Active status of bank account

Through the penny drop process, the central record agencies will validate the bank account that an individual has provided by remitting `1 and the transaction will validate the details on the name of the account holder, bank, and IFSC with the name in the Permanent Retirement Account Number (PRAN) or as per the documents submitted.

The regulator in its circular has underlined that the 'penny drop' can happen at the time of processing of the exit/withdrawal request. The response of success or failure will be provided by the service provider based on validation of the savings bank account number name checked as per CRA—K Fin Technologies (KCRA) and NSDL e-Governance infrastructure (NCRA)—records.

If the bank account details and other details are not correct, the alternate account number or additional supporting documents will have to be submitted for updating the records. In case the penny drop fails at the time of processing, the point-of-presence or the subscriber will be informed to correct the bank account number and resubmit the application so that the withdrawal request can be processed in a time bound manner.

Moreover, the CRAs will have to inform the subscriber to not modify or close the existing bank account once the exit or partial withdrawal request is given till the time the amount is credited to the account.

Partial, premature and final withdrawal

After retirement, a subscriber can withdraw 60% of the accumulated corpus as lump sum and has to mandatorily buy an annuity plan for the 40% of the remaining corpus. It is mandatory for the NPS subscribers to purchase an annuity product from an empanelled life insurance company known as annuity service provider (ASP). The subscriber selects the ASP at the time of submitting the withdrawal request or after the payment of lump sum withdrawal. However, if the accumulated corpus is less than Rs 5 lakh, then the subscriber can withdraw the entire amount.

In NPS, a subscriber can opt for a premature exit. Any exit, before completion of three years is treated as premature exit. In such a case, 20% of the accumulated corpus can be withdrawn as lumpsum and the rest (80%) is invested with a life insurance company empanelled by PFRDA for buying annuity. However, if the total corpus is less than or equal to Rs 2.5 lakh, then the entire amount can be withdrawn.

A subscriber can go for partial withdrawal for treatment of critical illnesses, higher education of children, marriage of children and for purchase/construction of residence. A subscriber should be in NPS atleast for three years and the amount to be withdrawn should not exceed 25% of the contributions made by the subscriber. The partial withdrawal can be done for a maximum of three times during the entire tenure of subscription.

(The writer is Saikat Neogi.)

TOP

IRDAI CIRCULARS

Topic	*Reference*
Health Products for 2021-22	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4544&flag=1
List of Main Products/Add-ons noted during the FY 2021-22(April 2021-June2021)	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4545&flag=1
Terms and Conditions of Life Products for F.Y. 2021-22	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4546&flag=1
List of corporate agents registered with the authority as on 31.07.2021	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo2818&flag=1
Gross direct premium underwritten for and upto the month of July, 2021	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4543&flag=1
First Year Premium of Life Insurers for the Period ended 31st July, 2021	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4541&flag=1
New Business Data as at 31.07.2021(Line of Business wise)	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4542&flag=1

TOP

GLOBAL NEWS

China: Regulator tightens crackdown on errant Internet insurance activities – Asia Insurance Review

The CBIRC is making Internet insurance a major focus of its supervisory work, covering in particular misleading sales, forced bundling of insurance plans, high costs, and illegal operations such as the leakage of information. These are areas where the frequency of violations is high.

The regulator recently issued its “Notice on Carrying out Special Rectification of Internet Insurance Chaos" which says that in recent years, online insurance has moved into the fast lane. “At the same time, transgressions have been rampant,” stated the notice. It added, “Some Internet platforms are suspected of illegally engaging in insurance business. Some insurance institutions have significant pricing risks in their Internet insurance products, lack sufficient offline service capabilities, engage in misleading sales, and generate complaints and disputes.

“Many problems, such as high service fees and the illegal use of user information, urgently need to be rectified.” The remedial action targets product management, sales management, claims management, information security and other areas that are often chaotic.

The CBIRC encourages companies to address the violations voluntarily and says those that fail to comply will face “severe punishment”.

The CBIRC issued the regulation, "Internet Insurance Business Supervision Measures" in December last year that took effect from 1 February 2021. The Measures lay down clear regulatory requirements for institutions to conduct Internet insurance business. This special rectification exercise is an important element of the implementation of the Measures.

The rectification drive is being led by the Non-Banking Inspection Bureau of the CBIRC with the participation of the Consumer Insurance Bureau, the P&C Insurance Department, the Personal Insurance Department, and the Intermediaries Department. The State Council has warned of more legislation to come in areas including national security, technological innovation as well as anti-monopoly action.

TOP

Thailand: Draft marine insurance law being reviewed - Asia Insurance Review

A draft of Thailand's much-awaited marine insurance law is currently being reviewed by the Office of the Council of State, a department under the Prime Minister that provides legal advice to Thai state agencies. Mr Phusit Rattanakul Sereeruengrit, director of the Office of Trade Policy and Strategy (OCP), says that Thailand has to push the marine insurance law as it would help support and create confidence in trade, according to a report by the newspaper Matichon.

However, although Thailand has enacted laws relating to international trade and international shipping, there is still a lack of legislation specifically related to marine insurance. The Thai market therefore commonly adopts or refers to English law as the governing law for marine insurance policies. Stakeholders have been working on a marine insurance law for some time. In January 2019, the Thai Cabinet agreed to propose the Marine Insurance Bill, as prepared by the Ministry of Finance, to lawmakers for consideration.

The Bill, among other things, sets out the rights and duties between insurers and the insured; how to calculate the compensation amount and the deadline for claims to be filed, the methods of indemnification, definitions of marine insurance terms, and the enforceability of marine insurance contracts in the transportation of goods by sea within Thailand and overseas.

TOP

Thailand: Life insurance sector deliberates pension products - Asia Insurance Review

The Thai Life Assurance Association (TLIA) and the Office of Insurance Commission (OIC) are currently in talks with life insurance companies to design and develop pension insurance products to meet retirement funding needs, according to Mr Sara Lamsam, TLIA president.

He said that pension plans would respond to the current aging trend in Thailand. “They would strengthen the savings discipline of the people to a level that is sufficient for their well-being after retirement,” he said.

Mr Sara added that pension plan proposals needed to be ironed out with the insurance regulator and the tax authorities, according to a report on the news website, Economic Base.

He also disclosed that for the first six months of this year, the life insurance sector chalked up total premiums of THB294.9bn ($8.8bn), representing an increase of 3.13% compared to the corresponding period last year. New-business premiums surged by 9.88% to THB83.7bn in 1H2021. These consisted of first-year premiums of THB45.9bn, a year-on-year decrease of 7.5%, and single premiums of THB37.8bn, which was an increase of 42.3%.

For the whole of 2021, life insurance business is predicted to generate total premiums of between THB590bn to THB610bn, which would be a conservative estimate, given that the COVID-19 pandemic has not improved, said Mr Sara. This would represent a change of -1% to +1% over 2020 when total premiums stood.

TOP

Indonesia: Insurance industry growth expected to continue at least till end of the year - Asia Insurance Review

The insurance industry is forecast to continue to grow till the end of this year after showing a positive performance in the first six month, in terms of premium growth, penetration and density. For example, in 1H2021, life insurance premiums grew by 18.35% year-on-year while general insurance premiums increased by 2.5%, according to a report on the news site Beritasatu.com.

Mr Tatang Nurhidayat, chairman of the Indonesian Insurance Council (DAI), believes this positive trend will continue until the end of the year, although it is difficult to predict the absolute figures because of the economic uncertainty caused by the COVID-19 pandemic. “If we look at the fundamentals, and at the first and second quarters, we are optimistic that this year can be passed better than last year," said Mr Tatang.

He said that for the insurance industry to continue to grow, insurance players must also be able to change in order to respond to new conditions. Changes are needed in areas such as product innovation and marketing, etc. He added, “However, because we are in a risky business, I think prudence remains a guideline. So it doesn't just change, but caution and good governance must be improved."

Innovation is key

Echoing the need for change, BRI Insurance CEO Fankar Umran said, "We see that this pandemic has a wide impact everywhere, both on health and the economy. If the economy is affected, cash flow will be affected. Then we must also look at changes in people's behaviour in transactions and also people's expectations."

Various strategies and innovations are also being carried out by BRI Insurance in order to continue to grow. For example, in responding to the declining cash flow in the community, it has been necessary to design affordable products. An example is to allow customers to pay premiums monthly instead of annually. Insurers have to innovate by adopting digital platforms so that they can reach more people amid movement restrictions, said Mr Fankar.

General insurance

Meanwhile, the chairman of the Indonesian General Insurance Association (AAUI) Mr Hastanto Sri Margi WI dodo highlighted the decline in the Manufacturing Purchasing Managers' Index (PMI) to 40.1 in July 2021 whereas previously it was above 50. This condition will be a challenge for the insurance industry going forward, he said.

"Although in the second quarter of 2021, there was economic growth of 7.07%, we see Indonesia's PMI in July 2021 drop significantly from 53 to only 40.1. This indicates a tremendous contraction in manufacturing. So we are very worried about this because it might cause a lot of cancellations. We hope that the PMI decline in July will not continue in August," Mr WI dodo said.

TOP