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QUOTE OF THE WEEK

"Choosing to be positive and having a grateful attitude is going to determine how you're going to live your life."

Joel Osteen

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Death benefit

Death benefit is a colloquially used term in life insurance. It refers to all the benefits under a life insurance policy paid to the beneficiary (nominee) on the death of the policy holder. It is the sum assured in a term insurance plan, and sum assured plus bonuses/guaranteed additions in the case of endowment plans.

Most insurance companies pay the sum assured as one lumpsum, though some offer to pay it over regular intervals as monthly or annual income to the nominee.

IRDAI's regulation mandates that in any life insurance policy, the sum assured should not be less than 10 times the annual premium for individuals below 45 years.

For older individuals, the sum assured needs to be at least seven times the annual premium.

One exception here is policies of tenor less than 10 years, where the sum assured has to be at least five times the premium. That said, at any point, the cover amount under the policy will have to be at least 105 per cent of all premiums paid till date of the claim.

Source

INSURANCE INDUSTRY

Can contributory databases in Indian insurance sector deliver greater returns – Analytics India – 18th May 2019

Technology is the beacon of paradigm shifts across all walks of life, be it in businesses, economies or people's day-to-day lives. Most industries are rapidly adapting technological processes to save costs and time and increase productivity, efficiency and ultimately profitability.

The primary goal of all the stakeholders currently – insurers, the regulatory authority, the government and consumers – is to raise the penetration of life, health and motor insurance to enable policyholders to protect themselves from unforeseen circumstances. While the insurance regulatory authority has been at the forefront of creating a favourable environment for both insurance companies and consumers, there is much more that could be done.

A recent report by Assocham reveals that insurance penetration in India has moved from 3.3% in 2014 to 3.44% in 2015, attributable to the various insurance schemes that the government launched. India's insurance penetration as a whole in 2015 was 3.4%, against the world average of 6.2%.

While adaptation to new technology has enabled the rapid growth of markets for a large number of industries, a key player in the Indian economy – the burgeoning insurance industry – is yet to fully leverage the varied uses of technology to effect faster growth.

Although the insurance sector was privatised a few decades ago, insurance companies continue to hold bleeding portfolios, largely due to poor loss ratios, underwriting losses and claims frauds. Given the long history of insurance companies in the country, it is evident that they hold reams of data which, if digitized and analyzed appropriately, could help yield significant insights for effective premium pricing,

underwriting of risk, curbing fraudulent claims, and ensuring a more personalized customer experience. A big way to stem these losses is through the adoption of advanced data analytics solutions.

While policy makers are in the process of creating a balance between privacy and the need to allow data to be used for legitimate and beneficial purposes, India has witnessed the first step towards a Data Privacy regime. By defining individuals as data principals and processors as data fiduciaries, it has enabled the committee to enhance the autonomy of the individual and places a great degree of responsibility on the processor to maintain trust.

In India, data analytics is a phenomenon that insurance companies are just starting to adopt. Some of the basic advantages of data analytics include faster and better decision making to gain a competitive advantage with unique insights from proprietary data. An example of these insights is a closer understanding of an individual customer's lifestyle, from health factors to what kind of vehicle they drive, which can be highly predictive of insurance risk. Boosting these insights, would be an intelligence exchange platform which enables industry data to be shared amongst insurers (large and small), with data being pooled from all segments of the total population.

While an insurance company gains basic insights from its own data, there are exponentially more benefits that can be derived through data sharing, if handled securely by a trusted third party. A comprehensive database would provide deeper and more accurate insights into the lifecycle of the population set Data analytics applied to larger pools of data would also help insurance companies better understand their current and potential consumers, price premiums more accurately, and reduce the incidence of frauds.

An example of a smart data intelligence exchange would be one that holds multiple consumer data points – including their current and past policies, health declarations, claims history, agent network, habits and preferences, all of which aid in making better underwriting decisions at the time of policy issuance, claims payouts and policy renewals. It is time that the Indian insurance companies consider data sharing and analytics as an easy way to leapfrog into the information age.

Contributory databases are commonplace in more mature insurance sectors such as in the United States. The creation and usage of a contributory database calls for open and transparent sharing amongst all the players in the marketplace, supported by a trusted provider of data, analytics and customer insights. Insurers of all sizes benefit from having access to more information than if they are operating in isolation. With this backdrop, the Indian insurance segment must work towards creating a synergistic decision to pool in their data into such contributory databases.

(The writer Shivakumar Shankar (Shiv) is Managing Director, India, for LexisNexis Risk Solutions.)

TOP

Source

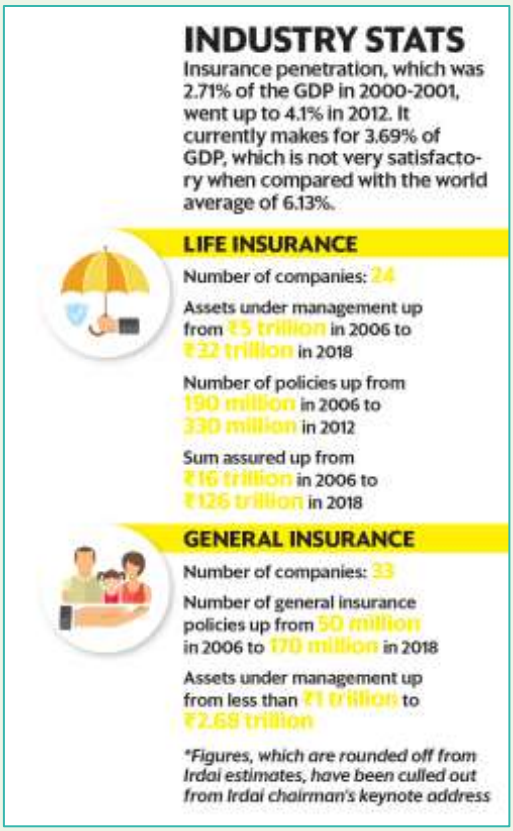
INSURANCE REGULATION

We are requesting the govt to allow Aadhaar-based KYC in insurance: Irdai chief – Mint – 19th May 2019

It will be 20 years next year of the insurance industry opening up to the private sector. Mint's Insurance Conclave 2019, held on 14 May in Mumbai, debated what the last 20 years in the insurance industry have been like in terms of laying the foundation for both life and non-life insurers and what changes the industry would possibly witness in the next 20 years.

The chairman of the Insurance Regulatory and Development Authority of India (Irdai), Subhash Chandra Khuntia, delivered the keynote address at Mint's insurance conclave held in Mumbai on 14 May. Here are the edited excerpts from his address.

The Indian insurance industry started during the British time with only private sector participation to begin with. There was a proliferation of insurance companies then and that resulted in the formation of the Legislation Insurance Act of 1938, to regulate the sector. We then nationalised the life insurance industry in 1956, followed by nationalisation of the general insurers and then on the basis of the Malhotra Committee report, the government decided to liberalize the sector and allow private sector participation. When we allowed the private sector to participate, naturally, the issue of regulation had to be brought in and the IRDAI Act was passed.



with more players, higher turnover, newer Starting from 2000-2001, we have seen the private sector flourish and the insurance sector has grown—products, new and better distribution channels and greater visibility of the sector.

If we look back at the last 20 years, we will realise that in the first year itself, several regulations came into being, including appointing an actuary system, a prescribed minimum solvency margin, exposure and prudential norms for investment, regulations and disclosures, and reinsurance norms. In the same year, we had four private life insurance companies and three private general insurance companies.

I would broadly divide the last 18 years into three phases of six years each. Between 2000-2001 and 2005-2006, new channels of distribution came into being. Brokers entered the sector for the first time and so did corporate agents who were formerly working with banks and other financial institutions.

These brokers and agents leveraged the wide network they had which resulted in enhancement of insurance penetration in the country. During the same period, we prescribed educational qualification, training requirements and examinations for sales and service personnel to ensure ethical behaviour. A code of conduct was also put in place. We also came up with a regulation for the protection of policyholders. Rural and social sector obligation also came into being during this period so as to push the insurance companies from metropolitan areas to inner lands.

Then, micro insurance as a concept was developed to leverage the presence of small NGOs, self-help groups and micro-finance institutions to tap the low-income segments by selling low-premium, affordable products. Towards the fag end of this period, we also introduced the concept of stand-alone health insurance companies and we have seven such insurers today.

The next phase, between 2006-2007 and 2011-2012, saw domination of unit-linked insurance plans (Ulips). They became very popular at the beginning of this period but thereafter there was huge volatility in the market which affected their stability. By 2011-2012, the growth in this area decreased. Irdai was then compelled to come out with certain regulations to protect the policyholders. This was done by prescribing reduction in yield criteria, minimum surrender charges and enhanced disclosure norms.

In the general insurance sector, the fixed tariff rule was removed which resulted in steep reduction in the premium rates due to competition. Though competition is good in a deregulated economy but it did have some negative impact—there was some erosion of pricing discipline and underwriting losses were also observed in some cases. During this period, the Insurance Information Bureau (IIB) was formed by Irdai to use data analytics for pricing and underwriting policies, and for the prevention of fraud. Irdai also insisted on mandatory public disclosure.

The next six years, between 2012-13 and 2017-18, Irdai drafted new regulations for life insurance products to address market conduct issues and to improve transparency. During this period, the Insurance Act was amended substantially. As a result, several regulations underwent changes to bring in a new framework. Foreign shareholding which was earlier fixed at 26% was raised to 49%.

New channels of distribution like web aggregators and POS (points of sale) were introduced to improve insurance penetration. Insurance repositories were brought in for maintenance and updation of policies. Foreign reinsurance branches were allowed in the country after the legislative changes and now we have 10 such branches. During the same period, six companies got listed, which improved disclosure, transparency and public scrutiny. Irdai wanted to make it compulsory for all insurance companies to get listed after a certain number of years of existence but this has not been accepted by the industry.

As we have seen, the growth in insurance sector is above the economic growth rate and I think this will continue for the next 20 years. The overall CAGR (compounded annual growth rate) in life insurance is 10-12%. General insurance is growing at about 18% and stand-alone health insurance companies are growing at about 40%. We have tremendous scope as far as health insurance is concerned. There are already 120 million policyholders through government-initiated schemes.

Reinsurance is another sector where we have the General Insurance Corp., which is now among the 10 largest reinsurers globally. With our demographic profile and high economic growth rate, the need for protection will grow.

In the next 20 years, we should also look at how the demographic profile is changing and what would the future needs be because traditional insurance products may not be useful for the millennial, Gen Y and Gen Z generations. The next revolution will be on artificial intelligence, robotics and bioinformatics; digital, biological and physical processes will all get combined together. This would require new types of products.

There will be a huge need for cyber security insurance and liability insurance. Need-based insurance is something that we will have to prepare ourselves to provide to the next generations. User-based insurance or bite-sized insurance products will be designed during underwriting depending upon the quantum of usage, nature of usage and policyholder's behaviour. This will be possible because of the huge amount of data which would be available with the insurance companies. Of course from the regulatory point of view, we will have to be quite watchful.

The use of digital technology is changing the entire landscape of how we work. There is also a sort of societal transformation and the insurance sector can exploit this to innovate products, to use it in the entire value chain—starting from underwriting to relationship management with the clients, for claim settlement, grievance redressal, pricing and feedback.

I do not suggest complete digitisation because it may not work in remote areas. However, digital technology should be used to increase outreach even in the most remote areas and for disseminating information, helping distribution channels to sell products more ethically and reduce mis-selling. Face-to-face contact will also be necessary. Both digital technology and personal relationship will have to be used to sell insurance products.

We are requesting the government to allow Aadhaar-based KYC in insurance as well. Banks and telecom companies have already been allowed. Insurance and insurtech companies need to use simple KYC so they don't spend too much time and customers do not have to wait for too long before they get the product.

We have come up with a draft regulatory sandbox mechanism and have sought views of the stakeholders. Some of the regulatory provisions may not work for innovating products and processes, and since new developments are coming up in the insurtech space, sandbox will allow them to partially relax some of the regulatory provisions for a short period of time. Regulations can be modified later, if need be.

Twenty years is too long a period to think about what is going to happen. The risks will keep changing. The biggest emerging risk now is of climate change. In the last couple of years, so many natural disasters have struck us. Insurance companies have to be prepared for such unusual risks.

TOP

Source

LIFE INSURANCE

Postal Life Insurance: Did you know PLI is not only for government employees? Check your eligibility – Financial Express – 20th May 2019

In addition to the 24 life insurance companies being governed by the IRDAI, postal life insurance has several insurance policies on offer. There are six PLI polices to choose from and all of them are traditional in nature, i.e. not market-linked.

Since 1894, postal life insurance (PLI) was available only to the government and semi-government employees, including the employees of public sector undertakings, financial institutions, and nationalized banks, but back in 2017, it was made open to a more wider section of the population. Life insurance policies under PLI has been made available to professionals such as Doctors, Engineers, Management Consultants, Charted Accountants, Architects, Lawyers, Bankers etc. and to employees of listed companies of NSE (National Stock Exchange) and BSE (Bombay Stock Exchange).

PLI plans

So, in addition to the 24 life insurance companies being governed by the IRDAI, the postal life insurance has several insurance polices on offer and managed by the Department of Posts under the Ministry of Communications. That brings in the element of sovereign guarantee in the PLI polices as is equally available to life insurance policies issued by the government owned Life Insurance Corporation.

There are six PLI polices to choose from and all of them are tradtional in nature, i.e. not market-linked. These are – Whole Life Assurance (Suraksha), Endowment Assurance (Santosh), Convertible Whole Life Assurance (Suvidha), Anticipated Endowment Assurance (Sumangal), Joint Life Assurance (Yugal Suraksha) and Children Policy (Bal Jeevan Bima).

The maximum limit of life insurance (sum assured) is Rs 50 lakh as a total of any PLI policy. In PLI for the Endowment Assurance plan, the rate of bonus has been Rs 58 per thousand of sum assured while for Whole Life Assurance it has bee Rs 85 per thousand of of sum assured for the last few years in a row.

Buying PLI online

In addition to the authorised post office branches, one can buy any of the PLI polices online by visiting the India Post website.

Once bought, in order to view and carry out transactions relating to the Postal Life Insurance policies on real time basis, generation of Customer ID is a pre-requisite. However, before, generating the Customer ID on the Portal, ensure that your Mobile number and email id are updated in the system against the respective policy.

By accessing the above link and on clicking on 'Generate Customer ID' button, a pop-up appears where one has to fill some mandatory information such as Policy Number, Sum Assured, Insured First Name, email id etc. After all the mandatory information is filled up, click on submit button, then customer ID will be sent to your registered email id with link for resetting the password.

On the online platform after making PLI login, one is also given premium payment option and facility of generation of SMS alerts like premium due, premium payment, maturity due etc. are also there on the platform.

TOP

Source

Do senior citizens need term insurance? - Deccan Chronicle – 20th May 2019

A term insurance policy is a working person's preferred financial protection instrument. Upon their death, the policy will pay a sum assured to their nominees whose long-term income needs will be taken care of. However, the same financial challenges may dog someone who has retired or is on the verge of retirement. Senior citizens may also have liabilities that are far from being settled — such as a home loan. They may have dependent family members — parents, spouse or children — with income needs that may outlast their own lifespans. It's also plausible that their savings after the age of 60 are insufficient to sustain their dependents.

Life expectancy, too, is on the rise, almost doubling from 35.4 in 1950 to 68.3 in 2015. Women, often the nominees of life insurance policies, have a higher life expectancy of 70 years versus 67 for men, as per WHO data. Income needs increase with life spans, and therefore life cover may be required even at a late-life stage.

A term insurance policy provides low-cost life coverage with no investment benefits. Any person who meets the eligibility criteria can purchase one.

CAN SENIOR CITIZENS BUY TERM INSURANCE?

Yes, they can, albeit with certain limitations. Every term plan has an age eligibility criterion. Individuals between ages 18 and 60-65 can buy term insurance. The criteria vary from one insurance company to another as do the features of the policy. The lowest tenure of such policies may be 5 years going upwards of 80 years, depending on your age. For example, one insurance company allows you to buy its term plan at the age of 18 with a maximum tenure of 67 years, which means your coverage bought at the age of 18 will expire at the age of 85. There is also the option of full-life coverage, which may extend to the age of 99 or even 100 years!

SUM ASSURED & PREMIUMS

The minimum sum assured of such plans is typically upwards of Rs 10 lakh. There may be no upper limit for the coverage with most leading insurance companies. The premium is influenced by three factors - your current age, your coverage requirement, and the tenure of the insurance coverage. The higher these three are, the bigger your premium will be. The premiums can be paid monthly, semi-annually or annually, as well as through a one-time payment before the start of the policy tenure. Additionally, many policies also allow you the option of paying premiums up to the age of 60 (till the end of your working life) while the coverage itself may extend well beyond that age.

HOW TO BUY

A term plan can be purchased online or offline after a due comparison of all options. Most term insurance policies require senior citizens to complete a pre-purchase medical test to ascertain their health conditions and whether they're suffering from pre-existing medical conditions. While applying for any life or health insurance policy, correctly disclose all material facts about your health. Concealing any information, misleading the insurer, and providing incorrect information can later become grounds for claim denial.

ADD-ONS

Like most term plan offerings, senior citizens too can include a variety of add-ons to boost their basic coverage. Of course, this comes at an additional cost. Some well-known add-ons today are monthly income (which pay the nominee a fixed monthly income over and above the basic sum assured), accidental death benefit (which pay an additional sum if the insured's death is caused in an accident), waiver of premium (where future premiums are waived off upon the diagnosis of terminal illness), and critical illness cover (where you are paid a lump sum upon the diagnosis of a listed illness).

If you're a senior citizen whose family will need financial assistance after your death, you should consider having a term insurance plan in your financial kitty.

TOP

Source

Life insurance industry to focus on millennials, digital-human interface – Mint – 19th May, 2019

The topic of the second panel discussion at Mint's insurance conclave was: Life insurance 20-20: Issues for the next 20 years. On the panel were: B.Venugopal, managing director (MD), Life Insurance Corp. of India (LIC); N.S. Kannan, MD and chief executive officer (CEO), ICICI Prudential Life Insurance Co. Ltd; Prashant Tripathy, MD and CEO, Max Life Insurance Co. Ltd; R.M. Vishakha, MD and CEO, IndiaFirst Life Insurance Co. Ltd; and Vibha Padalkar, MD and CEO, HDFC Life Insurance Co. Ltd. The discussion was moderated by Monika Halan, consulting editor, Mint. Here are the edited excerpts:

Monika Halan: Life insurance has come a long way in the last 20 years. However, for me, some basic issues still remain. When I look at the industry from the point of view of a consumer, disclosures, persistency, and misselling have been large issues for the industry. The 2010 reform for Ulips, had it also been extended to traditional policies in some way, the industry today possibly may have been very different. I am going to start with Venugopal. LIC has meant insurance for a whole generation of Indians but the structure of the products that LIC has produced and sold has been—very little insurance cover with more of an investment. It is more like an FD with a crust of insurance. LIC went through its own experimentation of Ulip products over the 2009-2010 period and then it reverted back to traditional. So there has been sort of a rethink within LIC on the product portfolio. So if you could just take us through how LIC has looked back in the 20 years of the product mix.

B. Venugopal: In my view, it is not correct to say that we have focused only on investment-based products because ultimately we believe that somebody who buys insurance has a purpose of risk cover that is paramount for any product. But it has been the case in our country; of course, the experience in other countries would be different. The focus has been on products which sometimes offer returns also because we had still not come to a stage where one was ready to buy a pure term insurance plan. That was the culture for a very long time before the industry opened up. After that, there has been some shift because the first unit linked product came in the year 2000 or 2001. In the initial enthusiasm, we also sold at a large number. But as you mentioned, perhaps not all of them were sold the right way. So many people burned their fingers but people also made money. But our realisation is that, as a life insurer, our primary responsibility is to ensure coverage. Today things have changed substantially. Look at the product mix that LIC has; out of total Rs25 lakh crore of life fund that we have, hardly Rs43,000 crore is of unit linked. But for everyone else, the ratio is 51-49. I think out of Rs6.60 lakh crore fund sizes for all the companies put together, Rs3.34 lakh crore is unit linked. Now whether this product mix is right or wrong, it is ultimately for the customers to decide. But as an institution, we would like to develop a product mix that is ultimately the choice of the customer. It is not that we have abandoned unit-linked

products. Right now we have only one unit linked product; there is another one in the offing. This year, we have consciously decided to focus a little more on some of those areas where perhaps we have not spent as much time.

Halan: Kannan, I want to come to you and ask what ICICI Pru has gone through. The DNA has changed several times at how the company has looked at insurance. Any insights on where you are today; you are listed, so what is it that you have learnt as a firm?

Kannan: If you are talking about the whole journey of the 18-year period, one of the things that we have been clear about right from the beginning is that we have to be a multi-channel multi-product company and that basic ethos has been there in the company for a long time. To talk about some of the new channels which emerged when we started the business—back then it was only an agency-dominated business. We started off with bancassurance and we were one of the first companies to start that. At that time, it was more of a referral model; banks becoming a corporate agency as a model did not exist at that time. So we started out with bancassurance. Then later, we hired corporate agents, brokers and now we have online web aggregators as well as direct business. So the ethos has been to reach the customers. We have to have our own channels and also go through all the other channels who in turn have a longer and deeper relationship with customers. I think that ethos has been pretty much there from the beginning and that's the reason why if we look at our channel mix today, it is about 50-55% bancassurance, then about 20-22% agency and then the remaining in rest of the channels including web aggregators including corporate agents and brokers. So I think in a country like India with a pan-Indian opportunity which is there, there is a need to further expand in terms of policies, a multi channel architecture would be required. In terms of products, we were one of the first ones to introduce Ulips. We look at Ulip as a product which is extremely transparent from the perspective of charges being known very clearly to the customer. Then we have this benefit illustration where we show how the fund is going to move depending on the market movement, and the charges have been very transparently laid out. And of course, once the customer buys it, he is also subject to the daily vagaries of the NAV depending on the market condition. So there are a set of customers out there who understand that the investment is subject to market to market vagaries and everything has been laid out. That's the customer who buys that product. Then as you said, 2010 regulatory changes happened, where essentially the product become a long-term product and minimum lock-in was stipulated and I thought that the regulator did a smart thing by saying that let us go through the investment-led protection but let us layover a minimum protection of ten times so that insurance can be achieved through the route of investment itself and I think that it was a smart move that has led to the Rs127 crore of sum assured that we talk of today. That is something that we started off with. So our philosophy on the product is also a multi-product company. There are certain set of customers, certain set of distributors who would be comfortable in selling Ulip and there are other set of customers for whom the traditional products give their own value proposition. But the key across all the products is persistency. When a customer stays for a longer time he gets the benefit, whether it is in a traditional product or Ulip.

Halan: Vishakha, you have moved from a general insurance person to life insurance. As you entered this very different industry, what are the two-three things that you were surprised by—both positively and negatively?

R.M. Vishakha: It is going to sound very surprising but I didn't know what endowment was. I joined in 2001from a non-life sector and honestly at that point of time, it wasn't that we had a lot of money; none of us were really investing in mutual funds. Mutual funds were new. I remember I had one SBI mutual fund and I said what do I do to redeem it and they said the value isn't much for it right now; just leave it as it is for now. And I actually redeemed it 20 years later. I didn't know what NAV calculation was. For me, the entire concept itself of how endowment products work, how NAVs work, how Ulips work was new. You have to remember that in 2001, Ulips were just a traditional policy unwrapped. You had high charges. I accepted everything as it was because I didn't have any background. You know when you are a sales person, you take the product, you see the positioning, and you say okay this is where it will work, these are the people I can pitch to and you go and pitch a product. So that's really how you look at it. But when you start looking at it from a CEO-perspective, then you realise, when we started India First in

2009, the Ulips products had been stripped off of all its charges. Traditional products didn't have any lapse profits that the companies could take. So I think the more I saw it from that perspective, I started realising the immense amount of difference that the regulations have made. However, the public perception has not caught on with the kind of regulatory changes that have been made.

Halan: Prashant, how does your foreign partner, the Japanese, look at the Indian market and the regulations, the state of the industry, and the way business is done? What are the insights that they bring into the board room or in the way the company is run? Also, do they have a view on the stage of the Indian market; do other countries typically go through the process that we have gone through in terms of product structure and product mix?

Prashant Tripathy: The good part was that the foreign partners came in 2012. Ever since, though the pace of regulatory changes has remained pretty strong and there has been a series of regulatory changes that have come, being from much matured markets, I think I haven't heard them talk about the kind of product mix that we maintain within our company to be extremely out of sync. Those products are common even in Japan. The focus on protection and pure term is much higher in Japan, which is the direction that the industry is moving in. Secondly, with their experience, it's an evolution that we all are going through. The pace of change in India is definitely higher than how it's been for many other countries. It's because of the buzzing population, how the regulatory framework has evolved. I think, overall focus with respect to changes in India will continue to be higher. What gives lot of comfort to our partner, especially the shareholders, is how the industry and our company have evolved in last 5-6 years versus how it was from 2001-2010. Coming from outside, the first few years were bizarre. The persistency numbers and the distributor compensation, especially with respect to Ulip, were pretty high and that's what was being sold. People were creating lapse-supported products; so all that is gone now. If you really take a step back and think about the health measures, they have significantly improved for everybody. So that gives a lot of comfort to our shareholders.

Halan: Venugopal, I want to start again with LIC because LIC defines that traditional approach to insurance for us. LIC talks about extremely good claims ratio and it is very impressive, but then I look at the persistency numbers and a 61st month persistency number is still less than 50%. When you look at the product structure, other than the term products, it is really more of an investment—a fixed deposit product with a crust of insurance. When we look at claims, then it is not really the risk that is getting covered, it is really the investment made by the individual which comes back with some interest. A lot of this conversation comes out into the open with technology; especially with the younger people who are very focussed on what they get out of a product. Concepts like IRR, XIRR, which maybe the older generation did not understand now will be on an app. How do you look at the future in the context of all that I have described—of the demand bulge shifting to a very different part of the population, technology coming in, court-based intervention and the macro changing itself; how do you see LIC then?

Venugopal: The first 20 years has been a journey of discovery and growing up for everyone. Till 20 years back, we were the only ones; whatever we did was okay and acceptable. Now many things have changed, many distribution channels have come in, and the way business is done has changed. As you said, the expectations from customers, especially the younger ones have all changed. But first to speak for LIC itself, what is it that we should do in the next 20 years? I think the biggest answer to that has come from what the chairman said. He spoke about the coverage gap, which in life is about 90%. That is still in terms of premium. But the more striking fact is that in last year's annual report of Irdai, it says that only about 22% of the Indian population are covered. For us, as in institution, that was created to spread the message of life insurance to every nook and corner of the country, that is the biggest challenge. We exist because people need insurance. So for the entire industry, for the next 20 years, the focus has to be on bridging this gap. Unfortunately, we allowed ourselves to be measured in terms of yardsticks which are not relevant to our country because we talk about penetration, we talk about density and both are based on premium. It is very easy for both of them to grow with no new person buying but if they buy more, both of them will grow. So real measure should be how many persons are insured. So for us, that is very clear. We will focus on getting more and more people across the country getting the cover. What else we will do is that in every stage of growth, you need to look at how you will attract the customer and you

need to design products which are more relevant. Last year itself, we have started the journey where right at the top, the focus are the millennials—what is their behaviour, what kind of products they would like. When I joined the industry 30-35 years back, most people's worry was that they might die very young. It has now significantly shifted to the worry of living long. Everyone has given up including the government offering anybody defined benefit pension. So that is another shift that is happening and that will grow in my opinion. We will focus more on pension. Then health insurance, which is a very lowly used life insurance product of health; so my view is that these three will remain in focus. First to increase the coverage, second is to focus on products which are taking care of needs other than your pure life cover.

Halan: See, there is no surprise when an FD in my bank comes back; then why this celebration when a traditional plan which is essentially a fixed deposit with an insurance cover; why is there a celebration that look, my claims are so good. If the claims on pure term are 99%, then I will celebrate. So that has been my surprise that one, your persistency in 61st month and we don't know what the tenth year persistency is because Irdai does not disclose those numbers. And these are typically 15-20 year products. So we don't know what those persistency numbers are plus this is really FD money coming back. So that has been my disconnect.

Venugopal: The way I look at it is like this. Say 1,000 people buy insurance and only 4 die, you will be happy. If less than four die, everybody is happy. Now the fact is that when you buy a life insurance policy, there is an element of uncertainty. We hope that nobody dies. They live happily ever after. So the focus on term claim or death claim coming with a same level as other claim, that is very well taken. That is our attempt but there the issue is that these claims are predictable; so they get settled a little quicker. But you can compare our death claim settlement ratio and you will still find that they are extremely good. Persistency is an issue and I accept it; not just for us but for almost everyone it is an issue.

Halan: I want Kannan and Vishkha to debate on whether the next 20 years belong to Ulip or traditional investment plans.

Kannan: To answer your question, it is going to be neither. The future is going to be from a growth perspective, the protection and annuity. I think these are the two big segments we believe are going to be big opportunities. This is because, whether it is macro or consumer behaviour, there is going to be a sea change. So this will mean that for companies like us, in the industry, there is going to be a huge volume opportunity as well as a value opportunity. I say value opportunity because if you look at the working age, let's say 20-plus to be about 65 years; from about 800 million people today, it's going to be more than a billion people in the next 20 years. There are huge numbers of people working, saving and moving on. Then from 65-plus segment, which are going out of retirement, so that is going to go up and double at least. So there is a huge annuity opportunity out there. During this period, India's per capita income would have moved to about $2,000 from today to $10,000 in the next 20 years. So, look at the need for protection; whether it is a liability protection or income protection or the kind of aspirations and the needs we'll have for needs-based savings. We are a unique industry that can give protection to the family on a financial goal, whether the breadwinner exists or not. I think no other license in the financial sector services can give the power to achieve the family's goal even without the breadwinner not being there. That is a powerful license which has been given. So for a term insurance, instead of lump sum, there can be money for goal-based saving whether it is education or marriage, etc. Mark my words, it is going to be a decade of protection going forward.

R. M. Vishakha: I think completely differently. I think Kannan is right in side-stepping the whole thing on Ulip and traditional because we are talking 20 years. If we were talking five years, perhaps that debate would have been relevant. When you are talking 20 years; the way I want the industry to evolve and the way I visualize it is that money is very personal. All of this has served a purpose and the purpose has not just been protection as people call it but it is actually about risk management. Risks in terms of an individual are not just about how you invest but it is your ability to invest. The way I see it is, having that money when you need it and you have this entire ecosystem that works together—whether it is using blockhain technology or any other thing. But what is goal-based protection? Suppose your child is in

school, will that continue? So if you are around, will the school start charging a certain excess amount to continue to fund the fees of the child for the next 10 years and, therefore, is the saving actually linked into the school fees? So are you actually saving right through that? Are you actually then using a grocery store and the grocery store has an insurance and makes sure that if you are not alive, then that much of grocery keeps coming to your house irrespective of whether you save or don't save...

Halan: ...If a grocery store shuts down or school shuts down, then?

Vishakha: ...That's what I am talking about. I am not getting into how the whole "solution-ing" will happen, because there are obviously a lot of things; whether they will transfer or it will be a blockchain technology or if it will be wholly integrated. I will give you an analogy of how it has already started happening in health. It is not only the doctor who is not treating you. You have got a yoga teacher who is treating you, you have got your office telling you to walk up the stairs; everybody is starting to look at your health and it is not just you. It has shifted to the entire environment.

Halan: Vibha, you have strong views on how the regulator should allow life companies to allow health products. So looking at the next 20 years, why would a life company offer a general insurance product or why do you have standalone health companies and general insurance companies also offering the same. So are you thinking of collapsing the entire part of the industry?

Vibha Padalkar: So just dialling back, life companies used to be allowed to sell health indemnity products. There was some level of cover as we understand from the regulator that was given to standalone health companies. I have two points on this topic and why I feel extremely strong about this that life insurance companies should now, having given the cover for more than five years, be again allowed to sell health indemnity products apart from health benefit products. One is that the needle has moved very little and the requirement is enormous in India. An individual typically would have four or five health incidents in his or her immediate family situation. Also, the sheer numbers also show that even today 75-76% is paid out of pocket as against worldwide, which is about 18%. So really what are we quibbling about? There is enough and the customer out there is woefully under-penetrated. So we can just say that there is confusion in the minds of the consumer. But is that really the case? Let the consumer deal with it with whatever disclosures that is required. Also, I feel that from a life perspective, health is just a part of that journey; artificially saying that one part of the journey I can't cover, but the other part I will cover. So ramping up of health and ramping down of mortality as a person who heads towards retirement is something that might make a lot of sense. So you keep a level premium and 'n' number of such offerings wherein it becomes seamless; where does mortality stop and morbidity start and vice versa. And these are all different aspects of protection. It becomes really restrictive. I am not saying that X part of what Irdai governs should not sell health insurance; I am just saying that we haven't moved the needle at all.

Kannan: Just to add to that, if you look at the overall distribution and reach of the whole life industry, we talk about 2 million agents and the whole bank branches and everything; I think it is going to be a great addition for increasing the health penetration in the country if we are also allowed to do similar type of things.

Halan: But why just stop at health; why not household or car, etc?

Kannan: I agree but as Vibha was saying, I want to supplement to ensure that mortality and morbidity go together....

Padalkar: ...And also, when you go for medical tests, it's a very minor effort from both sides—the company and the customer...

Kannan: ...And for the critical illness type of a product that each of us offer, anyway we have to have that expertise and the real expertise in writing that business. I think that the need of the country is so huge that these artificial boundaries over a period of time should be eliminated.

Halan: Prashant, how would you look at this? What do you see in the next 20 years; in terms of the product mix and catering to the new generation?

Tripathy: I will perhaps apply a few frames and let me begin with the frame—distribution. I think the distribution is going to undergo change. This model that we followed with respect to bank and agency, while they will continue to remain dominant for a while; I think agency will have to change. And that change may not happen by the 180 degree shift from a human to complete computer or digital interface but quasi human-digital interface will be the future. It will have to move in that direction because as all these X, Y, Zs come into being, they will not be very comfortable dealing with a human being that is not transparent, who is not sharing, and who doesn't have the expertise to connect, and so on. So that one part of change will happen. Insurance agents may not fully go away but the agents will become more sophisticated who is ready to share the information which is required and is able to connect with customers who will appear after 20 years.

On products, I think, life insurance license is one of the most potent licenses. It is not simply about giving somebody the claim when he or she dies. It is in the business of managing risk through life events. You could debate saying that the value proposition that the life insurance company comes up with in normal saving product design is not good enough. But it will have to be increasingly good enough for it to continue to exist and I am sure that as companies continue to grow, the scale, the benefit, etc will come into being. I will say that life insurance will continue to manage these risks but life insurance will not compete on giving the best return to the customers; that is not our business. Several product designs might but life insurance as a whole will remain in the business of managing risk and not giving the best returns.

Halan: I hear the point that life insurance is not about giving a great return. There is a cost to guarantee and increasingly as the younger population comes into being the main market, you cannot not tell them what they are going to get. You cannot say that your returns are going to be a 120% of the sum assured; they will figure this out. The older generation could not figure it out but they will figure out that the IRR is 3%. So let the choice be with me as a customer to say, you know, what is the guarantee that I will get 5%? When we have an inflation targeting central bank, which is going to keep the inflation somewhere around 4%, if I am getting a guaranteed 5%, it is a very compelling argument. But tell me that it is 5%. So why will you not tell me what I am going to get, and why will you peg it to a third or fourth number? Vibha, I want to check with you that why would you disclose the returns of an annuity product without taking time value of money in mind, saying that it is a 12% return but the minute you take in time value of money, that return drops to 6%. So somewhere you will not be able to treat the policyholder the way they have been treated. So how does this go forward?

Padalkar: If someone is looking for a short-term investment horizon, then this is not the product...

Halan: But even long-term persistency is 44%; so where is your long term?

Padalkar: ...And it is both ways and it is slightly more complex. If you look at the structural aspects of Ulip, for example, which continues to be my pet peeve, you have almost removed every share of exit barrier and to hold the customer. Why is it that we are comfortable with the lock-in in PPF (Public Provident Fund), but not with Ulips.

Halan: Could it be the way it is sold? Sell a product as a five-year product and then you wonder why at the end of five years people have withdrawn...

Padalkar: Even after five years, it's one thing but why are they withdrawing after the first year, especially in a unit-linked construct where you get a 4.5% guarantee. Insurance companies largely have to invest it in G-secs. So you get, say a 7% return and it's treated as tax-free; though incorrectly but treated as tax-free. And there is no credit risk. You'll find very few products to beat that kind of an IRR; more so, if it is a financial large ticket investor. So, some of these things are structural to your point on persistency.

TOP

Source

Is it time to relax the seven-year rule for missing persons' insurance payouts? – MoneyControl – 18th May 2019

Pratik Vaishnava and his sister Kritika will give their board examinations in 2020. Their mother could not choose a nearby CBSE school in Kanpur because of a tough financial situation. Her husband who was an alcoholic has been missing for the past five years and she has to wait two more years before getting a term insurance claim from the insurer.

Life insurance companies use a seven-year rule in case of a missing person to determine the death of a person. Any death claims filed by the family members of a missing person is stored in the system after a police complaint is filed. A waiver is only given in case of natural calamities like earthquake, flash floods, landslides or cyclones. Insurance company officials said that the idea was to avoid paying fraudulent claims when the person was still alive. Insurers lose almost Rs 3,000 crore every year due to such frauds.

Claim settlement officers of companies point out cases where family members file a fake missing complaint to get Rs 10-15 lakh worth insurance claims settled. The investigation officers were able to track the person who admitted that he faked being kidnapped to get a claim passed.

Doing a detailed underwriting before a policy is issued can help prevent any fraudulent claims being filed later. The seven-year missing person rule can also be done away with in this case. Waiting for seven years to get death claims defeats the whole person of buying a pure term life insurance product. In a majority of cases, the person could be dead and the family suffers from financial troubles when the bread earner is absent.

Data from the National Crime Records Bureau showed that out of total 5,49,008 missing persons during the year 2016, a total of 2,29,381 persons were traced and 3,19,627 persons were untraced at the end of the year. While this is the latest official data available, estimates suggest that 50-55 percent missing person remained untraced even after three years.

On the other hand, there are almost 45,000 unidentified bodies every year in India. Considering at least 30-40 percent of these individuals would have taken a basic life cover, their families would have to wait for a long time to get the claims settled.

As a start, insurers could reduce the missing person claim period to three years. Fraudsters would not wait three years for an insurance claim since they are out to make a quick buck. Genuine policyholders, on the other hand, would be benefitted since insurance is the only instrument specifically intended to act as an income replacement for a family without a bread earner.

TOP

Source

GENERAL INSURANCE

Home insurance must cover accidental deaths due to cylinder explosions: IRDAI panel report – MoneyControl – 21st May 2019

Insurance of home structure must cover accidental death due to gas cylinder explosion for a reasonable amount, the Insurance Regulatory and Development Authority of India (IRDAI) has said in a working group report on fire insurance for dwellings, offices and shops.

Almost 4,000 lives are lost every year in India due to gas cylinder or stove blasts. With home insurance covering such incidents, financial payouts will also be made accordingly.

The regulator said there should be only one product for fire and allied perils for dwellings of any value. All existing products with varying terms and coverage should cease to exist.

The regulator has proposed three categories of home insurance. One would be home insurance for home buildings and contents.

The second would be micro commercial insurance for commercial enterprises whose value at risk at one location per policyholder is up to Rs five crore.

This will include insurance for the building, plant and machinery, trade equipment, stock in trade and other trade-related contents.

The third category would be small commercial insurance for commercial enterprises whose value at risk at one location per policyholder exceed Rs five crore but are up to Rs 50 crore. This will include insurance for building, plant and machinery, trade equipment as well as the stock.

The report said the existence of multiple products in the fire category with differing words creates confusion amongst this segment of customers whose awareness about insurance is anyway low. It said that insurers must not be allowed to vary the terms, conditions, coverage and add-ons for these products.

Insurance for catastrophic incidents

The working group said recent catastrophic events like J&K Floods, HudHud Cyclone, Chennai Floods, and Vardha Cyclone in India have revealed that the economic losses are far higher than the insured losses. This highlighted the poor penetration of property insurance in the country.

In the product for the dwellings, commercial enterprises and the MSME sector, the report suggested covering all catastrophic perils in the base policy itself. It also proposed that there be no provision made in the policy for a discount in the premium offered to the insured for opting out of this cover.

It suggested that the government could fund these losses by the use of instruments like catastrophe bonds.

Catastrophe bonds or Cat bonds are a new method of transferring insurance risk to the capital markets. The proceeds from the sale of the bond are invested in near risk-free instruments to generate normal market returns. This gets combined with insurance company's premium and allows the bond to pay a higher spread over money market returns.

These returns are paid through periodical coupons to investors. If no insurance event occurs the investor receives the higher coupon for the term of the bond, usually three years, and receives the principal back at maturity.

If one of the insured events occurs, all or part of the principal is transferred to the insurance company, the investor's coupon payments cease or are reduced, and at maturity, there is either zero, or a reduced amount of principal repaid.

Keeping in view the high volatility of natural catastrophe (NAT CAT) losses, their increasing frequency and the likely high premium rates, the working group could not reach a conclusion on recommending a standalone NAT CAT insurance product.

However, it said that the best solution to NAT CAT perils appears to be government funding reinsured by Cat bonds.

TOP

Source

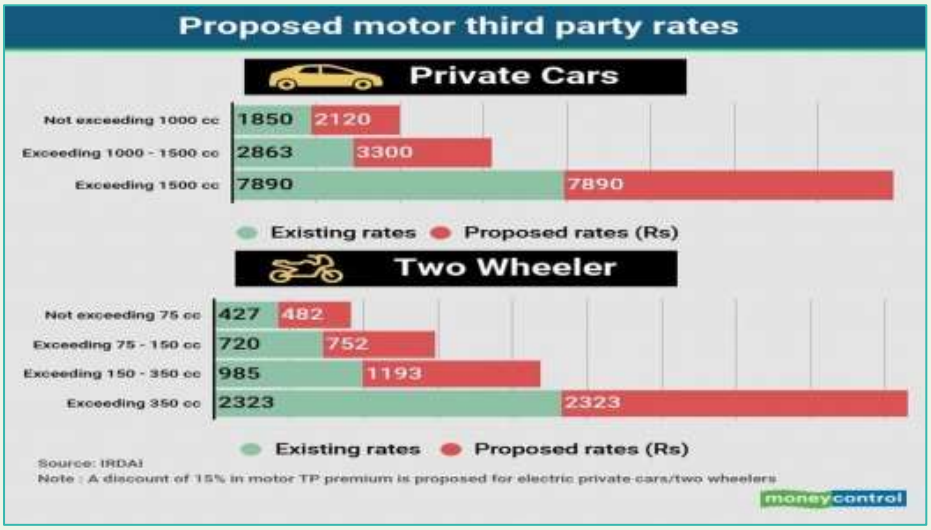
General insurers' losses may narrow as IRDAI raises third-party motor premium – MoneyControl – 21st May 2019

The third-party motor premium is set to be revised upward this year after a two-month pause. The premium, proposed to be increased between 4-21 percent for two wheelers and four wheelers, is likely to help reduce underwriting losses in this segment.

A majority of general insurance companies posted an underwriting loss in the motor insurance segment due to an increase in the claims from this segment. On the other hand, sales of passenger vehicles and two-wheelers were merely up 2.7 percent and 4.86 percent, respectively in FY19 (according to SIAM data) which led to a direct impact on the sale of motor insurance.

New India Assurance, for instance, posted an underwriting loss of Rs 563.67 crore in the motor segment for the March quarter of FY19 in comparison to Rs 116.89 crore loss in the year-ago period. For the full year, the underwriting losses rose to Rs 1,528.20 crore which is 2.4 times that of the previous year.

Similarly, for ICICI Lombard General Insurance, the underwriting loss in the motor business stood at Rs 155.49 crore in Q4 compared to Rs 23.36 crore underwriting profit in the same quarter previous fiscal. However, motor insurance saw a 22 percent rise in the premium collection to Rs 6,423 crore in FY19.



Infographics by Ritesh Presswala

"We hope that in some time there is a price increase in motor third party insurance by the regulator. If not, this will impact our loss ratios in FY20," Bhargav Dasgupta, MD and CEO, ICICI Lombard General Insurance had said during the earnings call.

While the Insurance Regulatory and Development Authority of India (IRDAI) had earlier in March said the motor rates will be on hold, the high claims ratio has led to this decision. Third party motor insurance rates are fixed on an annual basis by IRDAI based on the type of vehicle, engine capacity and the claims data in that particular category.

Sanjay Seth, Executive Vice President, IFFCO Tokio General Insurance said, "Keeping in line with the prudent underwriting norms, premium rates have to match with claim experience of the industry. Currently, this is not happening in the Third Party (TP) motor insurance segment, especially when claims/losses are going haywire."

Consumer groups and transport lobbies had expressed concerns about the premium hike for vehicles. This was especially after the rates were increased twice in FY19, once in April and September.

In August 2018, the Supreme Court had mandated the sale of only three-year car insurance and five-year two-wheeler insurance for the third party segment from September 1 onward. This led to a rise in premiums by 2.86-3.08 times and 2.45-5.61 times for new cars and bikes purchased after this date, respectively.

The price hike, however, is not applicable for long-term policies. Further, there is a 15 percent discount for electric vehicles.

TOP

Source

Homeowners, small businesses can look forward to cheaper insurance cover soon – The Hindu – 21st May 2019

IRDAI panel moots changes in view of recent losses due to natural calamities

Individual homeowners and small businessmen living in regions prone to natural calamities can look for better cover soon.

In the wake of recent natural calamities resulting in huge loss of dwellings and commercial establishments, a working group of the Insurance Regulatory and Development Authority of India (IRDAI) has suggested a simple, affordable insurance cover for homeowners.

Similarly, different products for micro commercial establishments having a risk value of ₹5 crore and above ₹50 crore have been proposed. The inadequate sum insured for dwellings can be attributed to the fact that it is the customers who decide on it, with insurers having no say over the matter.

'Reasonable approximation'

Many a time, the customers insure homes for their purchase price.

However, "there has to be a system of default sum insured for all the dwellings such that the default sum insured is a reasonable approximation of the correct value of construction of the building," the working group said.

It also recommended insurance of home in multi-storied apartments for total saleable price of the apartment based on ready-reckoner rates published by each State government.

On the tenure, it has been suggested that there should be a five-year period of validity for dwelling structure policies.

Huge gap

According to the IRDAI, recent floods (Uttarakhand, Chennai and J&K) and cyclones (Phallin, Hudhud and Fani) have highlighted how economic losses far exceed insured losses.

For instance, the economic losses of the Uttarakhand floods, Cyclone Phallin and Hudhud have been pegged at ₹6,600 crore, ₹3,800 crore and ₹65,000, respectively, according to data available with the National Disaster Management Authority.

However, according to the IRDAI working group, the insured losses for the same were ₹3,000 crore, ₹600 crore and ₹4,000 crore, respectively. It is this kind of gap that calls for a re-look at the norms.

In addition, there have been no changes on the regulatory front in this segment. The product structure has remained almost the same since the All India Fire Tariff Revision, 1988, and the insurance needs are met by the Standard Fire and Special Perils Policy.

TOP

Source

Bicycle thieves: The surprising growth engine for Toffee Insurance – India Forbes – 20th May 2019

Soft-pedalling any issue, reckons Rohan Kumar, doesn't work. And when the numbers depict a shocking story, it's prudent to step on the pedal. Take, for instance, the latest report by German insurance company Coya. Strasbourg in France tops the bicycle theft chart, followed by Copenhagen in Denmark and Hangzhou in China. "It's a serious global menace," says Kumar, co-founder and CEO of Toffee Insurance, an insurtech startup that provides niche insurance products such as cover for cycle theft and

damages, daily commute insurance, dengue and backpack insurance. Riding a cycle might be child's play, says Kumar, but taking it lightly can burn a hole in your pocket. This is what bicycle-sharing startups in China realised when some of them closed down due to alarming level of thefts.

Back in India, though there is no official data for cycle thefts across cities, Kumar reckons the numbers are high. The reason: About 60 percent of insurance products sold by Toffee Insurance are against cycle theft. Such a high percentage, in a little under two years, is staggering. Toffee's second biggest insurance product is for backpacks, and third on the pecking order is cover for dengue. The cycle is driving growth for Toffee, which was started in July 2017, and has been selling this insurance cover through its network of over 1,000 cycle dealers across 120 cities.

The Gurugram-headquartered startup now plans to step on the pedal. The plan is to reach out to police stations across smaller towns across India, and sensitise consumers who have lost their cycles. "The size of the bicycle market in India is pegged at 16.3 million units," says Kumar. The problem, he explains, is simple. Though people took their cycling seriously, buying insurance never crossed their minds.

The second problem was even more unique. Registering a complaint against cycle theft was perceived to be frivolous, and the ones who did were ridiculed. "It's not a joke," says Kumar. Over 98 percent of bicycles in India are priced below Rs 8,000 and are mostly used for commuting. A paltry 30,000 units are premium cycles. "An insurance premium as low as Rs 180 per year protects your cycle against theft and damage," he says. About 20 million bicycles, he adds, are less than two years old.

Toffee raised $1.5 million in a seed funding round, led by Kalaari Capital, Omidyar Network and Accion Venture Lab, last May. It is also planning to dig deeper into data from the National Crime Records Bureau (NCRB) to find out cities and towns where cycle theft is rampant. The idea, explains Kumar, is to roll out an extensive on-ground campaign across such places to sensitise people and spread awareness about the need to get an insurance for cycle. So far, the startup's distribution strategy to sell cycle cover was focused on point-of-sale at the retailer level. A lot of engagement programmes, both for the sellers and buyers, were devised with a targeted approach. "It helped the brand build trust," avers Kumar.

Pedal pushers

Trust, interestingly, turned out to be the biggest problem for Toffee early in its life. And it was primarily for two reasons. Firstly, the concept of buying insurance for cycle was new. Similar to buying insurance while booking flight tickets, it was an exception, not the rule. Secondly, the mistrust generated due to poor consumer experience related to insurance in other fields: Claim settlement processes are usually long and stressful. Buyers were incredulous, says Kumar.

Then, the name itself—Toffee—made it hard for people to take seriously. "What is Toffee? Is it a local or an international brand? These were some of the routine volleys the brand had to face," he adds.

Toffee, say marketing experts, has smartly created a niche by focusing on unmet needs of consumers. For any new insurance player, especially a startup, the best chance against the biggies is differentiated positioning. "Toffee scores high on both counts: Name and offering," says Ashita Aggarwal, marketing professor at SP Jain Institute of Management and Research. When the big—desi as well as foreign players—were trying to sell life and medical insurance to Indians, Toffee tapped into a demand which was latent, but not there for taking as the lowest hanging fruit. "Making people opt for cover for cycle, backpack or dengue is sheer innovation," she says.

The cycle cover also comes at a time when the premium cycle market is about to take off in India. Even bicycle-sharing startups are warming up to the Indian market. "The headroom for growth is immense. The road to travel is endless," she adds.

Kumar says their foot will remain on the pedal. The target is to take pocket-sized insurance products to the masses, and make them pocket-friendly. Toffee hopes to make the concepts of risk mitigation and financial security accessible to all. For example, Kumar says, if a labourer is working at a construction site in the city and sending money home to her family, Toffee can offer her insurance to protect her salary in case of hospitalisation. "We're working with money remittance outlets to offer salary protection plans for precisely this reason," he says. The cycle, Kumar adds, is just the beginning of a journey. "Toffee has just hit the road," he says.

(The writer is Mr. Rohan Kumar, co-founder and CEO of Toffee Insurance)

TOP

Source

Listing helped the non-life insurance industry become more transparent – Mint – 19th May, 2019

The topic of the second panel discussion at Mint's insurance conclave was: Non-life insurance 20-20: Issues for the next 20 years. On the panel were Antony Jacob, managing director, Apollo Munich Health Insurance Co. Ltd; Bhargav Dasgupta, managing director and CEO, ICICI Lombard General Insurance Ltd; Rakesh Jain, executive director and CEO, Reliance General Insurance Co. Ltd; Warendra Sinha, MD and CEO, IFFCO Tokio General Insurance Co. Ltd; Alice G. Vaidyan, chairman and MD, General Insurance Corp. of India; and Deepti Bhaskaran, editor, personal finance, Mint. Here are the edited excerpts:

Deepti: I am going to ask our experts to sort of go back in time and pull a key reform that they think has shaped the industry thus far. I am going to start with you Antony.

Antony Jacob: I think the best part of the 20 years that have gone by is that today there is definitely a huge awareness of a tool called insurance, which is protection. It is a tool which is available for protecting different types of assets. But if I could just stick to one of them, which is health insurance, which I am personally involved in the last several years; I think there have been some outstanding changes. From a one size fits all products, which we had in the early years, today you have different types of products to actually cater to the different needs of our people.

Personally, being in health insurance, I have had some of the visitors from overseas to look at some of the features which our industry has built over the last 20 years and they have actually been replicated in other parts of the world. That speaks about the change which has happened. And I can give you one example. The whole concept of floater policies was not heard of in the part of the world. It came about not very long ago. Then the restore feature—restoring the sum insured if you busted it—multiplying it as a 100% bonus. So there are several things which have changed the landscape of health insurance. But having said that, I think there is much more to do.

Warendra Sinha: We are here wanting to talk about this decade and the decade to come in the future. I will take a small deviation and like to take you all to a decade before that also. I am 37 years old in the industry and when I joined in 1982, I am still not too sure what the total premium figures were but I don't think it was more than Rs500 crore for the whole non-life industry. Today we are talking about a Rs170,000 crore. One had never thought that this industry would grow with such leaps and bounds. There were four companies owned by the government and I belonged to one of them and honestly life

was fairly laid back, nobody complained, customers were happy with whatever we did. We were meant to be the good guys. We were all meant to be LIC fellows; so gradually we came into our own and I remember in 1987 when the mediclaim was introduced, it was a big thing; a standalone policy and health was the need of the hour. When we joined, fire and marine comprised of 50% of the portfolio. Today, they are less than 10% of the portfolio. So this is what happened in the 20 years before the market opened up. A lot of things happened. Private companies and the broking community came in, the in-house distribution channels like the government had development officers, etc; they became a run-off category. And the style of working became a lot more competitive and people started to look at technology.

Bhargav Dasgupta: If you look at the industry post liberalization opening up, we are still in the high teens. And typical of that age, there's been a lot of growth, lot of change, taking on the current incumbents; so all of that has happened. So you have seen lot of changes in terms of the products. And I am speaking specifically from the non-life side. You have seen the industry grow 17x; it was roughly about Rs10,000 crore in 2000-2001. It is about 17 times now. What is interesting, I think, is that there have been a lot of distribution reforms. One change that people don't talk about enough but I think we need to see more of is the disclosures, which if you go back even 10 years back, I don't think we had disclosures as what we see today. I will give you a small example. Irdai was the first regulator to come up with the grievance management system for customers. Track the number of complaints that we have seen as an industry post that change; so that is transparency, right? Customers get to know our numbers that are publicly available if you are interested. So that one small measure has actually changed the dynamics into the number of complaints, at least of non-life. So there are many small things we have seen. If you insist on looking at a big one, then it is the detariffication that happened in 2008. And that has completely changed the dynamics of the industry in terms of how you succeed in the new regime.

Rakesh Jain: First few years went into discovering the industry for many private companies, where there were only few people who wanted to attempt it at that stage. The most important thing that I think happened was the detarrifing in 2007. Of course, we had a few products before that which was without pricing control but that was marginal. But really in 2007, we really set out almost the whole of the industry on its own. People were left out to decide what they want to do and believe me, all of us were at crossroads. We made a lot of mistakes. We paid a lot for those mistakes as well. If I look at now, today I see the companies are getting listed, becoming transparent in the biggest sense. Apart from the policyholders, there will also be investors. If you really see, it is coming off age now. If we had not gone through some of these experiences, I would doubt that we would reach this stage today to really claim the next 20 years in the rightful manner.

Alice G Vaidyan: If you ask me personally, a lot of changes have happened. We are talking of a young nascent market as compared to the advanced saturated mature markets of the West. So things will only improve from here. Of course, lot of changes need to happen. From a regulatory point, I think many welcome changes have come in. But from a market perspective, what I thought from a reinsurers' point of view, GIC from a holding company became a pure reinsurer in 2000. We donned the mantle of reinsurer and that has worked well. So as a dominant reinsurer in the Indian market with a 65% market share, it has served us well. But after that, the biggest reform that I see as a reinsurer was that the market has opened up for foreign reinsurers. I think in a true spirit of competition, we have now more than 11 reinsurers in the market. I think it is the right way the markets should move. We are moving to a foreign reinsurance hub. I think we are in the making given the interest in the Indian market and given the growth potential for another two decades to come.

Bhaskaran: Listing to my mind was a milestone event and in terms of disclosures, I think there were a lot of metrics that came to light by which you evaluate the insurance industry—whether it was life or non-life. But has this change been of the industry or just of the companies that are listed? Is it just a listing phenomenon or is it the industry that is moving in that direction of looking at underwriting profits and their loss ratios?

Dasgupta: I will probably share from a company which is listed. But my guess is that this will be largely reflective of most companies. These metrics are not new. All of us anyway were being measured

internally on combined ratios and underwriting practices and on return on equity. It is just that now that some of us are listed, there is a lot of awareness as there is lot of interest of a different stakeholder, which is let's say the retail investor or the other investors. Secondly, there is lot more scrutiny. For a listed company, there will be always a lot more scrutiny than an unlisted company. So there is a lot more focus on delivering on some of these agendas for some companies related to the others. But it's really a shareholder objective. If a shareholder of an unlisted company wants to focus on combined ratios and I am aware of quite a few companies who do that; it's not just the listed companies who do that. The issue is that when in a relatively nascent industry, the transition of detarrification happens, there is a discovery process. Initially when the prices collapsed, all of us tried to discover how to write business in the new reality and there were learnings for us. Secondly, as new companies come in, there will be some amount of expense claim; they will have to build a business till they reach a certain stable level. I think the issue is again what the chairman said as well. A company after a certain point in time, maybe after 10-12 years, they should be able to deliver a healthy business, which is sustainable in terms of combined. So it is not so much about listing, it is about what the shareholders drive even for unlisted companies.

Bhaskaran: Wouldn't you agree that looking at underwriting profits is something that the industry should focus on? Is it something that the industry has adopted?

Dasgupta: You even heard the chairman talk about it. So it's something that even the regulator looks at. I think all of us understand that if you want to build a long-term sustainable business, you need to focus on underwriting because if you don't, at the end of the day, your customers may even have a poor experience. You need the money to pay claims. Secondly, where do you have the extra money to invest in future? So underwriting is a no-brainer; you have to focus on that. The point that I was making is that maybe certain companies when they enter a market, for some period of time they need a bit of leeway, which the regulation allows. But after a point in time, ideally most companies should focus on underwriting. It is not to do with a listed company or an unlisted company.

Rakesh: There will always be a few people who set the tone; but I broadly see a trend that most of the unlisted companies are held by people who are listed. So they are not above the scrutiny which generally a listed company would have. The second thing is, 15-20 years into any industry, everybody looks at the business model. And structurally speaking, these businesses are now getting recognised as valuable businesses. These are no longer a small subsidiary of a large entity. I think it is reflecting opportunity for the businesses also to demonstrate where they stand in the scheme of things. I think these things are unparalleled and irreversible. I want to also add that maybe this only can happen because anything you get into, you need to have an organised way of reaching there. A simple example is that this year we have seen a huge improvement in property rates. But if you really see, it is based on the data which the industry has compiled with the insurance bureau. Now, this bureau could not have gotten set on day 1. So in some sense, if people have to reach a certain stage of maturity and profitability, this can only happen when you start constructing this piece by piece over a period of time. Eventually some people within that will take the lead and others are very likely to follow.

Bhaskaran: I want to talk a bit about standardizing disclosures here. If you have been in the industry for some years, could you look at standardizing disclosures?

Vaidyan: Listed companies have more disclosures. If you go to any company's website, you get all the information. But I think listing in a way has changed the way we do business and that we have to admit. Even before the listing happened, lot of market corrections were happening; so it's basically the company's philosophy that drives it. So that culture had come in and market corrections are underway even now and listing has put some pressure that is anyway right because we are answerable to a lot of investors about the way we do business. So I think if you see the results, most of the companies have also done that and there has been an improvement. Like Victor Hugo said, there is nothing more powerful than an idea whose time has come. And I think this was the time we all were actually waiting for. The market needed to move to underwriting profits and I think that is happening.

Dasgupta: If I can just add to the point. There are all the NL1 to NL40 forms that we have. All of us have that on our website. It's just that a lot of them may not be aware and lot of them may not be interested. Now when you are listed, every analyst and most good investors are going in and finding some information out and grilling you. So that is one of the reasons why there is awareness because you are a listed entity. That is one aspect. The second aspect which is probably a larger issue is that we have a set of disclosures and it is a very positive development in our opinion over the years because disclosures bring in a lot of discipline on all aspects. And I use the example of customer grievances as one of them. The question is, as an industry are we ready for next level of disclosures, whether it is unlisted or listed? Now disclosures could be in terms of your health of the company, or in terms of more granular information about customer service. One of the points that we always raise is that if you look at one of the parameters that everyone looks at is how fast you settle your claims. Now let's look at each segment level. If you look at health, we will give you one number which does not tell you the difference between how well we are serving the retail customers and how well we are serving the corporate customers. And that's a good disclosure to have because the customer segments are different. Now let's say that your readership is potential retail customers who will be interested in buying a health insurance. They should ideally be aware of what is the experience of a company who has more retail customers. So these are all the nuances. So we need the next level of disclosures and it's not so much lack of disclosures from the unlisted companies. One of the issues that we face and we see because every company looks at other company's disclosures is some amount of lack of consistency in definitions and how we interpret those definitions and those things can be streamlined as we go along.

Bhaskaran: One of the things we decided to do three years back when we were rating health insurance plans was to reach out to companies and ask them for their retail level claims settlement data. A lot of companies didn't get back to us and a lot of them said they won't give it to us. They said we should take whatever is available in the public domain. So again, I am going to ask, do you think the next level disclosure is an idea whose time has come?

Jacob: Each of us do comparisons and all of our boards have people who understand insurance and comparisons are sort of mandated at a board level quarterly. So where do we get the information from? We go into other company's websites and the disclosures are a tool for us. In terms of the next level, of course, as the industry matures, we need to get deeper and deeper and the example which you quoted is absolutely relevant while health insurance is usually clubbed as a one piece but there are so many cuts to it. Today, it's just not retail and group. Deeper and deeper cuts is possibly what the industry needs at this point of time and I am so glad that there are media houses like yours which actually ask for that information and that makes us think and I am sure that all of us have that. It's just that some of us are prepared to share it and some others are not. But I personally think that's going to be the next wave we are going to get into, that is, detailed disclosures which are a welcome move.

Bhaskaran: In the non-life sector, we know that health insurance has become very popular but still, people are not insured enough. You have insurance from your employers or if you've bought yourself, the cover is not enough. Then motor insurance, because of its mandatory nature, people have motor insurance but even then there are large number of vehicles plying uninsured. When I look at past years, there is one catastrophe after another—Uttarakhand floods, J&K floods, Chennai floods, Kerala floods and now cyclone in Orissa, and yet, home insurance is not popular. When I look at home insurance, I find the product a little complicated but why do you think other kind of policies from the non-life segment are not becoming popular?

Sinha: Unfortunately in India, I have always maintained that insurance is not bought, it is sold. And you talked about motor insurance probably the mandatory thing which is third party liability, people buy in the first year and thereafter forget to renew it. As far as health insurance in concerned, till Ayushman Bharat did not come into the picture, the portfolio was 30% in terms of the population which was insured. Even with Ayushman Bharat coming in now, it's just about 50% of the population which is covered which means there is still so much to do. So probably, as a fraternity, we need to sell ourselves, advertise, tell people like the way mutual fund companies have done and I know there is something in the

offing. But everybody needs this at a small cost and if I can add, we probably would also want to say that we are not such bad fellows as we are made out to be.

Dasgupta: I think if you look at different product categories, we've seen a lot of interesting products out in the market. Something you haven't talked about, the bite-sized insurance which we call sachet products. If you look at mobile insurance products and retail cyber policies, there are lots of different categories that have come through. One category which hasn't really taken off to the extent it should have is home insurance. There is no debating that. My reading of the home product is that it's kind of derived from the traditional fire product and we've kind of structured it in that manner which is not really very retail friendly and if I look at a home insurance product, there are huge catastrophic losses when it happens; otherwise there is very little claims that you experience. So one way of looking at this is to possibly look at what are the real concerns that today's customers have and have we designed a product that addresses real concerns of today's customers beyond just a catastrophic event. I think as an industry we've not done that well. Secondly, you made the point about distribution and awareness creation; one of the things that we need to do is creating trust. My sense is that most home owners know about insurance, they probably have a motor and health insurance but they are not thinking of buying a home insurance and as an industry we need to ask the question, why? Is it a typical Indian consumer mindset that this won't happen to me or is it because there is trust deficit between them and the insurance company? If the claim comes, it may or may not get paid in a seamless and a smooth manner. So these are things that we need to fix. One of the things we can collectively do with the banking industry is that, in a lot of markets where there are high risks, there is some amount of mandation or incentivisation in a lot of markets to buy insurance. So one of the things that we can think of doing is, if there is a home insurance, then the capital charge from the bank should come down because you're taking away one element of risk even from the banker. These are some ideas we can think about and see what we can achieve but the point is valid that there is lot of scope in home.

Bhaskaran: When we talk about increasing the penetration, you talk about different products. But a lot of it has to do with simplifying the on-boarding process. It has to do with simplifying claims management and that brings me to the point of data analytics and data sharing within the sector. Insurance industry is not very forthcoming when it comes to data sharing because there are repositories and they're still sort of struggling to get everybody on board. Alice, do you think the insurance industry is doing enough with data analytics.

Vaidyan: At this point in time you are seeing a lot of changes happening. So though it might be true to some extent that companies do not want to share their data, the data is all available on each company's website. You are also now looking at technology changes and companies that have got on to the blockchain technology platform, companies that have moved to artificial intelligence and robotics, etc. So there is a general conception that data quality in the Indian market is not very high quality but I think we have enough data to help us to make whatever changes we want as far as technology is concerned. Almost 50% of the population feels that insurance is not affordable and that is because insurance companies tend to use formula of one size fits all because all we have to go by while pricing the product is insurace industry but if we have more data regarding the various products and across various lines of business, I think that will help us to bring down the pricing to an extent that it becomes affordable.

Bhaskaran: Often when we talk to insurers, we hear that regulations are very prescriptive. You know, you have expenses on management, and you have commissions that are capped. Everything is laid down but some companies still manage to pay over and above the commission and then some companies play by the book, and sort of lose out and are at a disadvantage. So one thing that I constantly hear is that maybe the regulation now needs to become more macro, leaving the management to the companies.

Vaidyan: I think what you just said is something that we all know is happening in the market. I also feel that macro management will help but the point is that all companies don't have a level playing field in the market. PSUs are bound by a lot of constraints and private sector companies have more operational freedom. I think getting into the granularity of regulations as the market is maturing; you can leave it to the companies because you are seeing more mature players in the market. We are not only talking of

companies, but also intermediaries and agents and many other players in the market. I think we are moving to that stage where we can leave it to the wisdom of the companies to have the regulations because being too prescriptive can harm companies.

Jain: With regulations, the challenge will always be that it should be contextual. You know what I would like is that the old regulations, the regulation which were created in 2000s and are not relevant need to be discarded so that the focus is only on the ones that are relevant. Regulations have to be contextual.

Jacob: Given where we are in the insurance space and so much more penetration is required, I can't see a situation where there won't be regulations. I am being practical about it; there will be but whether there is a need to continue to be micro, I don't think so. Plus I don't think the regulator is too micro to be honest. There have been opportunities given to the industry to go and talk to the regulator for changes. The regulator has always been open to discussions. I would like to see a little more of the macro. I would like to see combined operating ratio being looked at more seriously, at least the components of that. I would like to see the new approach being used for risk capital.

TOP

Source

HEALTH INSURANCE

Health insurance plans likely to have fewer exclusions – Financial Express – 24th May 2019

Health insurance policies will have less exclusions as the insurance regulator has come out with a draft exposure to rationalise and standardise the exclusions in health insurance contracts. No health insurance policy will exclude diseases contracted after taking the policy, it will not exclude injury or illness associated with hazardous activities and policies cannot exclude treatment of mental illness, stress or psychological disorders and neuro-degenerative disorders.

Health covers will also not exclude Age-Related Mascular Degeneration (ARMD), behavioural and neuro development disorders and even artificial life maintenance including life support machine use. Experts say rationalising exclusions will benefit policyholders and insurance companies will have to increase the premium.

Exclusions, waiting period

At present, all individual health insurance polices have a waiting period of 48 months in which no pre-existing diseases are covered. Hospitalisation expenses related to the declared ailments can be claimed after four years with the insurer. An insurance firm cannot deny a claim after four years of continuous coverage.

At the time of taking a health policy, the individual will have to declare any specific pre-existing diseases such as diabetes, high blood pressure, thyroid, etc. If an individual is suffering from any such disease, the insurance company will insist on a medical test and then underwrite the cover. There are certain ailments such as ENT disorders, hernia, osteoporosis for which the waiting period is usually one or two years.

Exclusion list trimmed

Last year, Irdai had directed insurance companies offering health insurance to cover treatment for mental illness. The directive follows the Mental Healthcare Act, 2017 making it mandatory for insurers to offer medical insurance for mental illness treatments similar to the ones offered for treatment of physical

illness. The draft exposure also underlines that treatment of mental illness, stress or psychological disorders and neuro-degenerative disorders will have to be covered.

There will be no exclusions on disorders of adult personality including gender-related problems, disorders of speech and language including stammering, dyslexia. Insurers cannot exclude expenses related to any admission primarily for enteral feedings and other nutritional and electrolyte supplements. Also, internal congenital diseases, genetic diseases or disorders cannot be put on the list of exclusions. Irdai has identified 17 existing diseases that can be permanently excluded.

Cover for modern treatment

To ensure that the policyholders are not denied availability of health insurance for modern treatment methods, insurers will have to ensure that procedures such as uterine artery embolisation, balloon sinuplasty, deep brain stimulation, oral chemotherapy, robotic surgeries, bronchical thermoplasty, etc., are covered. However, subject to product design, sublimits can be imposed for the above procedures.

Insurers will have to adopt an objective criterion while incorporating any limitations and that will be based on sound actuarial principles. In case of mon-declaration or misrepresentation of material facts that are seen during the course of the policy, insurers can permanently exclude the existing disease and continue with the policy. If the non-disclosed condition is other than from the list of permanent exclusion, then the insurer can incorporate additional waiting period of not more than four years for the undisclosed disease.

In case of non-disclosed conditions, the insurance company can continue with the cover by levying extra premium based on objective criteria laid down in the board-approved underwriting policy. After completion of eight continuous years under the policy, no look back can be applied. After the expiry of the moratorium period no health insurance policy will be contestable except for proven fraud and permanent exclusions specified in the policy contract.

(The writer is Saikat Neogi.)

TOP

Source

NHA to collaborate with cancer grid – The Hindu – 24th May 2019

Move is aimed at enhancing delivery of services under Ayushman Bharat-PMJAY

In the first such move to bring in uniform standards of patient care to battle cancer, the National Health Authority (NHA) and National Cancer Grid (NCG) have signed an MoU under the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY).

"The main objective of this collaboration includes developing uniform standards of patient care for prevention, diagnosis and treatment of cancer; providing specialised training and education in oncology, and facilitating collaborative basic, translational and clinical research in cancer," said a senior NHA official on Thursday.

Multi-disciplinary care

Dr. Indu Bhushan, Chief Executive Officer (CEO), Ayushman Bharat PM-JAY and the National Health Authority, said: "The partnership with the National Cancer Grid will bring in experts to enhance the cancer care services provided under AB-PMJAY."

He added that owing to the multi-disciplinary nature of care required for cancer management, both the NHA and NCG recognise the importance of collaborative efforts required to strengthen delivery of cancer services under AB-PMJAY.

Professor R. A. Badwe, Director, Tata Memorial Centre, added that its partnership with the NHA will allow implementation of top-notch standards across all levels of cancer treatment and care under the AB-PMJAY.

Joint review

The NHA and NCG will now jointly review existing cancer treatment packages, pricing of services, and standard treatment workflows covered under the AB-PMJAY, and plug-in necessary gaps to ensure enhanced quality of cancer care. Both organisations will work on creating cancer services/package benefits based on priority setting tenets such as evidence of efficacy, value (cost-effectiveness), low harm, demand/burden, medical necessity, and wide availability.

The NCG will work closely with the NHA to rationalise payment rates for different benefit packages and treatment/diagnosis plans, and also explore mechanisms to signal the right incentives to providers to ensure quality through pricing mechanisms. "We have to reduce the cancer burden in the population, ensure uniform standards of patient care towards effective and efficient patient-centric care, improve access to cancer services, and ensure financial risk protection with minimum prevalence of catastrophic health spending and impoverishment," added Dr. Bhushan.

TOP

Source

Healthcare Insurance in India – Perspective and Road Ahead – The Economic Times – 21st May 2019

India faces a unique challenge amongst all the countries as a large portion of the population lacks affordable and quality healthcare. The situation has not changed significantly from the last National Sample survey which showed that healthcare costs can be catastrophic for poor households. Less than 20% of the entire population has any kind of health insurance while the rest of 80% population has no health insurance at all. Large contribution of the health insurance (greater than 80%) comes from the government with private health insurance offerings catering to the wealthier segments of the population. The key concern remains the staggering out of pocket expenses that are borne by the household or the individual. Also, Government schemes typically do not pay for outpatient costs and private schemes limit the coverage to specific areas.

The government health policy has provided some protection in the form of state funded health insurance. While this alleviates the cost issues somewhat, the track record of these schemes has not been so good. One of the factors that seem to pose a problem is what is called as "health seeking behaviour", which is the tendency for medical bills for newly insured household to be higher than the amount insured. The bigger problem areas are when patients are denied coverage, cannot get coverage because hospitals are not been reimbursed or the actual costs are much higher compared to what was estimated by the insurance provider. The net result is that the costs paid out will continue to rise over time and exceed the amount collected via premiums. This makes it unsustainable for the insurance companies to provide the actual coverage as part of the government funded insurance.

There cannot possibly be a single silver bullet that can cure all these ailments. The solution will have to be dealt with at multiple levels including healthcare policy, implementation, monitoring and governance.

From an insurance perspective the elements that need to be addressed cluster around the following areas:

- The reimbursement focus should be not only on the treatment of the disease but also on the preventative care for the disease
- Address the abuse, waste and fraud that can potentially occur in the delivery of care
- Borrow from value-based models that have shown success in other healthcare markets in the world
- Make use of technology that brings simplicity and convenience to the end user while getting the job done for the care givers and the insurers

The prevalence of non-communicable diseases in India is very large - especially chronic conditions like diabetes and hypertension. The right setting for early detection, treatment and monitoring for these conditions is in primary care and most of the times preventative care methods can effectively manage these conditions. Increasing coverage of these areas will have a longer-term positive effect on the total cost of care and therefore reduce the overall cost of coverage for the insurer in the long term. This is an area of improvement going ahead which can be coupled with more work in making care accessible at a primary care level. There is also room to improve integration of primary care by way of referrals into secondary and tertiary care for these conditions.

Value based care has been implemented and has evolved into becoming a sustainable model of providing care. The balancing act of ensuring a better health of the patient for a reward/risk allows the care costs to be controlled with respect to quality. While value-based care is significantly up the ladder in terms of sophistication and cannot be attempted right away in the Indian context, there are several building blocks that insurance providers can put in place as preparatory steps. The most useful will be to collect data on costs and variations in cost of a wider variety of procedures. The data collection should allow for a standardized set of procedures to be paid for uniformly while allowing variations for demographics and disease stages amongst other things. This also allows for systematic ways to estimate for abuse or misuse of care, deliberate overuse and puts limits of coverage on potentially wasteful cost areas.

Last but not the least, digitization of the health lifecycle promises immense benefits. Ranging from creation of health records, to exchange of records at a regional or national level (subject to patient consent/privacy considerations) would really serve as a foundation that supports many of the other focus areas mentioned earlier. Health information exchange would also serve to integrate the primary, secondary and tertiary care via standard referral and discharge documents. It would also enable the act of claims processing to be more standardized and cost effective. With the advent of big data, the application of new technologies like machine learning and AI will provide significant returns on the overall digitization efforts.

While India faces a herculean task of making healthcare affordable and reducing expenses borne by patients, concerted efforts in some of these areas will certainly help us to move in the right direction towards a better healthcare infrastructure for everyone.

(The author is the Delivery Head, Clinical Health Care Practice at Persistent Systems.)

TOP

Source

Health insurance exclusions all set to reduce – Mint – 20th May 2019

- Irdai's draft exposure aims to enhance scope of health cover by rationalising and standardising health insurance exclusions through six key changes
- The draft is bound to have some impact on premium as the scope of cover has gone up and we will have to see how it will impact pricing

Putting in action the report of the working group set up to standardise and simplify exclusions in health insurance contracts, the insurance regulator has come out with draft exposure that aims to enhance the

scope of health cover by rationalising and standardising health insurance The Insurance Regulatory and Development Authority has sought public comments till the 31 May. We take you through some of the important features of the draft. But first, understand exclusions in a health insurance policy.

Exclusion in health policy

In order to protect the insurer from dangers of adverse selection, moral hazard or fraud health insurance contracts that pay per hospitalization broadly come with five types of exclusions, three of which are time bound exclusions. The first is the initial 30-day period during which time a policy doesn't pay claims on account of an illness. The second is disease-specific exclusion wherein certain ailments are excluded for a defined period. The third is the exclusion on pre-existing ailment in which the ailment is excluded in the initial years—up to four years. The fourth constitutes permanent exclusion where certain medical procedures are permanently excluded from the scope of cover such as cosmetic surgeries—unless it is required due to an accident and requires hospitalization; medical expenses on account of alcohol or drug use or birth control; sterility and infertility. The fifth is a list of non-payable items that constitute consumables and other non-medical items.

More cover, less exclusion

The draft has clearly defined what can or can't be excluded. For instance, the draft clearly states that any ailment that's contracted after the policy is bought can't be denied by the insurer. According to an insurer we spoke to on conditions of anonymity, since he was part of the working group, explained that currently other than standard exclusions, some ailments like Parkinson's disease and Alzeimer's disease also form a part of exclusions. The draft has trimmed and standardised exclusions which ensures ailment contracted after the policy is bought can't be excluded. The draft also states that health insurance policies can't exclude treatment on account of mental illness, internal congenital diseases or genetic disorders.

"Health insurance contracts sometimes excluded these ailments even if these ailments were contracted or found out after the policy was taken. Of course these ailments are covered only if any of these results in hospitalization. In case they are identified before buying the insurance, the insurer can take a call whether to insure the policyholder or not," said Kapil Mehta, co-founder, securenow.in. Further, in order to allow insurers to cover customers with pre-existing ailments they may not have otherwise insured, the draft has identified 17 pre-existing conditions that can be excluded and customers insured for other ailments.

Defining terms

The draft has also effectively tackled the definition of a pre-existing ailment that's loosely defined. Currently, even the presence of signs or symptoms can make an ailment pre-existing in nature and this has caused a lot of confusion. The draft now defines a pre-existing condition as a condition that's diagnosed by a physician or for which medical advice or treatment was received.

What it means for you

The draft has enhanced the scope of health insurance through six key changes: one, ailments contracted after buying health insurance can't be denied; two, the list of exclusions are standardised and trimmed; three, draft allows for permanent exclusions of pre-existing ailment; four, included lines of treatment due to medical advancement like chemotherapy and stem cell therapy; five, sharpened the definition to remove ambiguity; and six, a moratorium of eight years after which policy is not contestable except for proven fraud and permanent exclusion.

However this may not come without a hike in prices. "The draft has removed ambiguity and for the customer the 'ifs' and 'buts' have gone. But this is bound to have some impact on premium as the scope of cover has gone up and we will have to see how it will impact pricing," said Prasun Sikdar, managing director and chief executive officer, Cigna TTK Health Insurance Co. Ltd.

The draft has ushered in the much needed second wave of health insurance reform to make the policy more comprehensive. As per the draft, all products will have to conform to the guidelines by April 2020.

TOP

Source

Health insurance is a must-have for diabetics; but picking the right policy is the key – CNBC TV18 – 20th May 2019

Diabetes is a chronic condition. This essentially means that the person diagnosed with diabetes has to adjust to the demands of the illness and the therapy used to treat it for the rest of their life.

Diabetes affects various key functions of a person's body as it impacts the ability to process sugar due to irregular insulin production.

The number of people being diagnosed with diabetes is increasing exponentially in India, with a much higher incidence in urban geographies as compared to rural areas.

There are many factors which are contributing to the rise of diabetes but unhealthy eating habits and sedentary lifestyle are considered major causes, so much so that it is not uncommon to see Type 2 diabetes afflicting teenagers, generally those who are obese or overweight.

The treatment for diabetes related ailments such as heart disease, kidney disease and hypertension is expensive and prolonged. In cognisance of this, some health insurance companies don't just look at covering diabetes as part of standard health insurance plans but have also launched plans specifically tailored for diabetic patients, since diabetes-related ailments require specific and relevant coverages.

For example, owing to one's dependency on insulin injections as a way to control the illness on a daily basis, few insurers include that in the scope of coverage. Futhermore, unlike other insurance products, these plans offer a shorter wait-period of just two years to cover pre-existing ailments as diabetics who enrol might have one or more existing comorbidities.

It has also been observed that most people opt for an insurance at a progressed age and by then usually suffer from some or the other lifestyle-based illness – most common one being hypertension and diabetes. To ease the process for such individuals to get coverage, these plans offer enrolment without any pre-policy medical check-ups.

Care Freedom, which is a diabetes insurance product by Religare health insurance, not only accepts enrolment of individuals who take insulin, but also people who might be suffering from other diseases such as a mental disorders, anxiety and autism. Care Freedom also offers lifelong renewability which is an imperative feature considering that diabetes is a life-long disease which at best can be managed but not cured.

While many people are not aware about this, high-risk plans also come with high co-payments. Co-payment is the money which the insured person has to pay out of their own pocket in case of a claim. Diabetes is a high-risk disease and thus the insurance plans associated with it usually have high co-payments which can go as high as 50 percent; Care Freedom has capped co-pay at just 30 percent.

Since fast-paced stressful lifestyles combined with increasing pollution in urban cities have given way to a host of non-communicable diseases, which are both expensive and complex to treat, health insurance is no longer a luxury but a necessity.

Similarly, in the case of diabetes, whether it is genetic or environmental, having an insurance policy is always a good thing as it allows one to receive good quality treatment when they require it the most.

(Mr. Anuj Gulati is MD and CEO of Religare Health Insurance.)

TOP

Source

It's sensible to add critical illness cover to your health policy – The Hindu – 19th may 2019

CI policies provide additional financial support for high cost of treatment and a prolonged recovery period

A hospitalisation policy is a health insurance cover under which you can claim the actual cost incurred. In insurance parlance, it is called an indemnity policy.

A benefit policy, on the other hand, pays the sum insured (SI) as a lump sum when an insured event takes place, regardless of your expenditure. Critical Illness (CI) policies are benefit policies in health insurance under which claims can be made on diagnosis of one of the illnesses specified under the policy. They provide additional financial support for the high cost of treatment of these illnesses and for the prolonged recovery period when earnings may be affected.

Policy renewal

The advantage of taking a CI policy in addition to a hospitalisation policy is that you can make a claim under both policies for the same event. After this, the CI policy comes to an end while the hospitalisation policy can be renewed.

Most general insurance companies in India offer CI policies as do specialised health insurance companies.

They cover several named major illnesses, including coronary heart disease, cancer, kidney failure, stroke brain surgery and so on.

In addition, specialised policies for cancer are available from many companies; Future Generali Total Insurance Solutions has a heart cover alone. Many term life insurance policies offer a CI cover as an optional rider and they can be cheaper to buy although the list of illnesses could also be restricted.

Coming to the sum insured (SI), you can choose from ₹1 lakh to ₹50 lakh. If your CI cover is a rider on a term life policy, then the maximum sum assured (SA) on the rider would depend on the main SA of the policy as there are restrictions on rider premium in relation to the main policy premium.

Like any health policy, a CI policy has standard exclusions. Any pre-existing condition is excluded for an initial period of 3 or 4 years.

No claim is admissible for 90 days after inception of cover and other usual exclusions are any critical illness in presence of HIV infection and/or any AIDS, congenital diseases, abuse of drugs and alcohol and any treatment arising from pregnancy, miscarriage, maternity or birth.

The entire sum insured may not apply on each of the critical illnesses listed. There are claim limits for different illnesses and these vary by company as well.

There is also a survival period clause for payment of claim.

If the insured is diagnosed with one of the critical illnesses listed in the policy, he has to survive for a specified number of days after the diagnosis for the claim to be payable. This varies between policies and illnesses. In addition, a typical CI policy has no death benefit.

CI rider with term plan

To get around both these constraints you can buy a CI rider with a term plan.

The premium for CI cover as a rider is typically lower as well and this can be misleadingly attractive. For example, a ₹1 crore term life cover for a 28-year old male can have a ₹10 lakh CI cover at the cost of just ₹2,500 while a standalone CI cover can cost ₹6,000, but the illnesses covered are not uniform. So, the nature and number of illnesses covered by different riders and the cap on their claim amounts should be the factors you base your decision on.

There are also CI policies with return of premium which typically cost about 50-60% more.

Premium for CI policies carry benefits under Section 80D of the Income Tax Act, 1961 starting at ₹50,000 deduction if the insured is below 60 years of age and going up to ₹1 lakh if the insured and his parents are above 60 years old.

Range of options
CI policies range from the simple to the sophisticated and not just in terms of the quantum of cover they offer.

For example, Cigna TTK Health Insurance Company offers an extended policy that covers organ donors, offers an annual health check-up and the option to convert it into a comprehensive health plan after four years, that is a hospitalisation policy plus CI policy rolled into one.

Once your basic hospitalisation policy and any top-up policies are in place, it is time to consider a CI policy which can actually serve as a means of supporting your family through extended treatment and recovery phases.

Some extras in a hospitalisation policy are as follows.

***Free health check-up*:** Typical hospitalisation policies offer a free health check-up every three or four claim-free policy years. The amount reimbursable is usually a percentage of the SI with a cap.

Depending on age at entry or if there is adverse medical history, you will have to undergo a medical check-up at the proposal stage. This cost is to be borne by you, and half of it will be reimbursed if the proposal is accepted.

Daily allowance
Some hospitalisation policies offer a daily cash allowance for each day of hospital stay. This is usually a percentage of the SI with an overall cap per hospitalisation.

Unless it an optional extra purchased under the policy, the daily allowance will be deducted from your SI.

There are policies that pay the hospitalisation costs incurred by the insured on an organ donor. This will not include cost of the organ and the claim for the costs of the insured and donor should be within the SI of the policy.

Cover for a baby
On some policies, should an insured have a baby during a policy period, it is covered from the day of its birth until policy renewal date against illnesses and injuries.

(The writer K Nitya Kalyani is a business journalist specialising in insurance and corporate history)

TOP

Source

Health Insurance Claim: This is why your insurer may not pay the entire claim amount - Financial Express – 18th May 2019

The basic purpose of buying a health insurance policy is that one doesn't have to dip into one's savings to pay for the medical bills after hospitalisation. By paying the premium for a health insurance policy, one is expected to come out of the hospital without settling the bills. The cost of hospitalization is to be borne by the insurance company up to the sum insured opted by the insured.

However, even if one is carrying a cashless health cover that too in a network hospital of the insurer, there could be an instance when the insured may have to bear a portion of the medical bill as an out-of-pocket expense.

The reason why your claim may get paid partially is because of a clause called 'sub-limit' in the health insurance policy. The mention and the applicability of sub-limits are clearly there in the policy document but not many of us actually read and are in a position to comprehend the terms and conditions.

Before we see how it impacts, let us see what it is and how it works.

Sub-limit in a health insurance plan defines the maximum amount of coverage that the insurance company is liable to pay for each of the medical expense-head such as room rent, doctor fees etc during the hospitalization.

So, while the 'sum insured' defines the maximum amount of coverage of the policy which the insurer is liable to reimburse, the 'sub-limit' will be the internal caps of the various hospital expenses.

Room rent with sub-limit

Generally, with almost all insurers, the room-rent is fixed at 1 per cent of the sum insured. For example, in a policy with sub-limit having a sum insured of Rs 4 lakh, the daily room rent will be capped at Rs 4,000, which will be the policy's eligibility amount.

"If the sum insured is Rs 2 lakh and the daily room rent is Rs 4,000, you would get 50 per cent of the claim amount as the room rent is limited to 1 per cent of Rs 2 lakh i.e. 2,000 per day," says Rajagopal Rudraraju, Senior Vice President & Product Head – Health & Health Claims, Tata AIG General Insurance Company.

Proportional deduction

In a way, the insurers peg the room-rent to all other hospital expense-heads. And, if one takes a room with a daily rent higher than the policy's eligibility, there is a proportional deduction on all other expense-heads. "If any room is selected with a daily room rent higher than the eligible limit, they disallow not only the difference in room rent but also all other expenses in the same proportion," says Rudraraju.

This will make the insured to pay up the difference as an out-of-pocket expense because the insurer will not reimburse the amount exceeding the sub-limits cap.

There are, however, certain health insurance plans that do not come with any sub-limits. The premium of no sub-limits plans may be on the higher side but may avoid any unpleasant surprises during hospitalization. "As a general guide, the premium difference due to sub-limits would be smaller in higher sum insured plans, and larger in lower sum insured plans," informs Rudraraju.

What to do

So, what should a buyer do? Here is what Rudraraju suggests, "It is better to choose plans without room rent sub-limits. If they are to choose a plan with sub-limit, they should choose the limits such that they are reasonably adequate for the city they reside in.

For instance, if one has to choose a Rs 1 lakh plan with a 1 per cent room rent limit in a city like Mumbai, less than 30 per cent of the claim would eventually be paid." If you already have a health insurance policy, read the policy document carefully to see if there are sub-limits in it else as a new buyer choose plans that come with no or few sub-limits after carefully evaluating the premium and the features across the plans.

TOP

Source

Insurers can't deny cover for mental illness, adventure sports enthusiasts – The Economic Times – 18th May 2019

Insurance regulator IRDAI on Friday came out with new rules that will have widespread ramifications for health insurers and the general public. Insurers henceforth cannot decline coverage to those who have used opioids or anti-depressants. Nor can they exclude those with a history of clinical depression, personality disorders, sociopathy, psychopathy, or neuro-degenerative disorders.

They cannot exclude kids suffering from development disorders such as Down's syndrome, cerebral palsy, and autism, or those suffering from dyslexia, stammering and other disorders of speech and language. Batting for the LGBTQ community, IRDAI has said that insurers cannot discriminate on the basis of gender and identity. Insurers cannot refuse to provide coverage or reject claims if a person is on life support. Insurers can reject claims only if the patient is certified as being in a vegetative state, but even then insurers will be required to provide coverage/pay expenses till that date.

For young girls and older women who suffer from excessive bleeding, hormonal changes due to onset of puberty or menopause, insurers can no longer exclude coverage or payment for treatment costs. Insurers cannot deny coverage to geriatric patients, suffering from age-related macular degeneration (ARMD) and those suffering from rare or orphan diseases.

Insurers will have to cover adventure sports such as dirt biking, paragliding, whitewater rafting, go-karting, F1 racing, and ethnic sports like jallikattu and kambala. This would be a relief to sports enthusiasts, clubs and adventure trip organisers.

Another important decision is that at the point of claims if the person is discovered to be a smoker or suffering from a disease/pre-existing condition, the insurer cannot reject the claim if he/she has been availing of insurance for eight years in continuity.

IRDAI has said that insurers cannot exclude coverage or reject claims if the policyholder has "failed to seek or follow medical advice or follow treatment". Often patients undergoing treatment for a condition stop the treatment towards the final stages or stop taking drugs midway. Insurers have been known to penalise patients for failure to follow through on a prescribed regime.

TOP

Source

Mental, genetic ailments eligible for health cover under new Irdai norms – Business Standard – 17th May 2019

The Insurance Regulatory and Development Authority of India (Irdai) has listed diseases that can't be excluded from health insurance policies. It includes neurodevelopmental disorders, mental illness problems, psychological disorders, genetic diseases, puberty- and menopause-related disorders.

The insurance regulator said all health covers filed and cleared after April 1, 2019, have to adhere to the guidelines issued. And, all existing health covers which are not in adherence with the guidelines would not be offered and promoted from April 1, 2020, onwards.

With the number of health insurance companies and insurance products increasing in the market, the regulator wants the industry to adopt a uniform approach while incorporating exclusions in their products.

Also, any expense incurred by the policyholder for an illness within 30 days from the commencement of the policy will not be covered, except for claims after an accident. However, this will not be applicable for a policyholder who has continuous coverage for more than a year.

The regulator has also directed that no health insurance policy can be contested after completion of eight years, which is called the moratorium period of health covers, except for cases like frauds or permanent exclusions specified in the policy contract.

The insurers will also have to cover patients on artificial life maintenance, even when there are no chances of the patient recovering and not getting back to their previous health condition. However, expenses would only be covered up to the date of confirmation by the treating doctor.

The regulator has also named diseases that can be permanently excluded. The list consists of diseases like Alzheimer's disease, Parkinson's disease, malignant neoplasms, epilepsy, pancreatic diseases, chronic kidney disease, HIV & AIDS among others.

Insurers can incorporate waiting periods for any specific diseases but only up to four years. However, subject to product design, insurers are also allowed to impose sub limits or annual policy limits for specific diseases be it in terms of amount, percentage of sums insured or number of days of hospitalisation/ treatment in the policy, Irdai said.

TOP

Source

MOTOR INSURANCE

Hiking third-party motor insurance premium will hit truckers hard – Financial Express – 22nd May 2019

The truck industry is in for a trouble as the proposed hike in third-party motor insurance premium, coupled with an impending diesel price rise, are expected to hit the Indian freight market.

Caught under the idling fleet capacity across key trucking centres in the country with sharp fall in rentals due to poor freight availability, the truckers will find it difficult to absorb any cost escalations arising out of the proposed hike in TPM insurance premium.

At a time when the industry is going through a tough time due to slowdown in freight pick ups, the insurance regulator's proposal to go for a hike of anywhere between 10% and 20% on TPM insurance premium will further put pressure on the truckers and hence the government should ensure that the TPM insurance be detariffed to ensure free and fair play of market forces, said the Indian Foundation of Transport Research and Training (IFTRT), the apex body tracking the truck industry for more than two decades.

IFTRT has all along been urging the union government to detariff the TPM premium revision to take it out of the regulatory clutch, where motor general insurance companies with annual bonanza of premium

hike based on 'doctored data' to keep general public in good humour. But casualty is fair play and virtual extortion of hapless motor vehicle owners.

The Foundation has thus been asking the government that as there are almost 25 PSU and private corporates in general (non-life) insurance business, the third party premium should be detariffed with immediate effect like own damage motor insurance premium, in which 70-80% discount is being offered. Thus, due opportunity be given to free and fair play of market forces in third party motor premium revision to insurance companies rather than Irdai annually brokeraging TPP.

It is to be noted that as there is an all round economic slowdown, the truck rentals, in nut shell, have nosedived by 15% since November 2018 and overload has been taking place over the last few months. According to the Foundation, irrespective of exit polls, the road transport business has been put to an edge with double whammy of a possible diesel price hike to the extent of `3-4 per litre and 10-20% hike in TPM insurance premium at a time when the freight market is down with 25% drop in cargo offerings from factory gates, infrastructure projects.

Thus, coming months are expected to be a tough ride for truckers and how freight market to react to the unfolding developments is extremely worrying, IFTRT pointed out.

TOP

Source

Common reasons why motor insurance claims get rejected – Financial Express – 22nd May, 2019

Car insurance is mandatory in India and you buy an insurance plan mainly to secure yourself from heavy financial burdens that may levy on you alongside owning a vehicle. When you make a claim for a damage to your car, you expect an instant payback and if you are not being able to redeem your money, it can be very frustrating. Therefore, in order to avoid such a situation where you are not able to make a claim, you should familiarize yourself with the reasons why even a genuine claim made on your behalf may get rejected.

1. Driver Related Issues

Driving without a proper legal driving license or driving under intoxication are the two most common reasons why a claim in motor insurance gets rejected. The above actions are against the law and, hence, there's not much an insurer can do for you at the time of claim.

2. Non-renewal of Policy

It is important that you renew your policy every year before it expires. A claim against a policy whose tenure has expired is never entertained. To approach your insurance provider with an expired policy at the time of making a claim would get your claim rejected.

3. Delay in Reporting the Accident

Insurance providers expect you to report a claim incident as soon as possible but also provide a cushion of window. However, if you take ever too long to make a claim and do not provide your insurance provider with the right documentation within the given time-frame, your claim may get rejected. If your car has been damaged, make it a thumb rule to first report it to your insurance company before you give it in for repair.

4. Adding Accessories or Modifying the Vehicle

A policy is renewed and automatically covers the components available in previous policy. However, if you wish to cover additional accessories in your policy which were not covered earlier, you must inform your insurer about it. Your insurer will include these components post a successful inspection and

charging an additional premium. Failure to do so always results in rejection of claim for these additional components.

5. Driving Out of specified geographical Limits
If your accident has taken place outside of the geographical limit defined by your insurance policy, the claim does get rejected. Your motor policy includes the coverage of your vehicle on Indian territory and you will not be awarded a claim benefit against any mishap outside of country boundaries e.g. Sri Lanka, Pakistan, Maldives etc.

6. Wear and Tear of the Vehicle
Peeling of paint, degradation of tires etc. are a few common factors which come under normal wear and tear of the vehicle and are not considered under a claim benefit for your car insurance. Claim for your car is always against any accidental damage or a theft scenario.

7. Improper use of the Vehicle
Vehicle premiums are defined basis their usage as well. For instance, premium for a vehicle which is being used for private purpose is always different when the same is used for a commercial purpose. So, you cannot expect the insurer to provide a claim benefit if you change the usage.

Making a claim for motor insurance is the easiest and most basic of processes that people have to follow in order to get their money's worth. Taking into account the above-mentioned reasons will only be beneficial for you, as you move forward to make a claim against your motor policy.

(By Tarun Mathur, Chief Business Officer-General Insurance, Policybazaar.com)

Source

TOP

Insurance regulator proposes higher third-party premium for cars, two-wheelers – The Hindu – 20th May 2019

Regulator moots discount for electric vehicles

Third-party motor insurance premium rates are set to go up in the current financial year. Though new premium rates generally come into effect from April 1 every year, the Insurance Regulatory and Development Authority of India (IRDAI) had allowed last year's rates to continue till now.

New rates
The draft notification released by the IRDAI on Monday proposes to increase the premium rates for mandatory third-party cover by about 15 per cent for cars, while the hike in premium varies for other categories of vehicles.

The premium for cars below 1,000 cc will increase to ₹2,120 from the existing ₹1,850, an increase of 14.5 per cent.

In the case of cars between 1,000 cc and 1,500 cc, the premium being proposed to be increased is ₹3,300, from the existing ₹2,863.

However, no change has been mooted for luxury cars (with engine capacity of more than 1,500 cc) from the existing ₹7,890.

Two-wheeler rates
The new premium proposed for two-wheelers below 75 cc is ₹482 (from ₹427), while there will be no hike for bikes exceeding 350 cc.

No change has been suggested in the single premium for a three-year policy for new cars and five-year policy for new two-wheelers.

The regulator has offered a special discount of 15 per cent in the premium for electric private cars and electric two-wheelers, while no hike is planned in the premium for e-rickshaws.

Premium for other categories of vehicles, such as taxis, buses, trucks and tractors is also proposed to be increased at varying rates. The regulator has sought comments from stakeholders before May 29. It is likely to make the new rates applicable from June 1, 2019, sources said.

TOP

Source

INSURANCE CASES

Reimbursement claim: Insurance firm asked to pay 4.80L – The Times of India – 23rd May 2019

The District Consumer Disputes Redressal forum has directed an insurance company to pay Rs 4,80,805 along with 8% annual interest on account of late payment to a local resident, whose claim was earlier repudiated. The company has also been directed to pay the amount within 30 days.

Rishi Kumar, a resident of Ferozepur City, had filed a complaint against an insurance company, saying he had deposited all the relevant bills for reimbursement claim. He said his claim was rejected on the ground that the company was not be liable to make any payment under this policy in respect of any expenses incurred by the insured person during the first two years.

TOP

Source

Don't ask an insurance agent to fill up the policy proposal – The Telegraph – 20th May 2019

An insurance policy is generally bought for financial support during adversities. But when it comes to buying a policy, it is not wise to blindly put your signature without reading the fine print. The difficulties may compound if a claim is rejected at the time of need and you get no benefit from the years of premium paid to keep the policy in force.

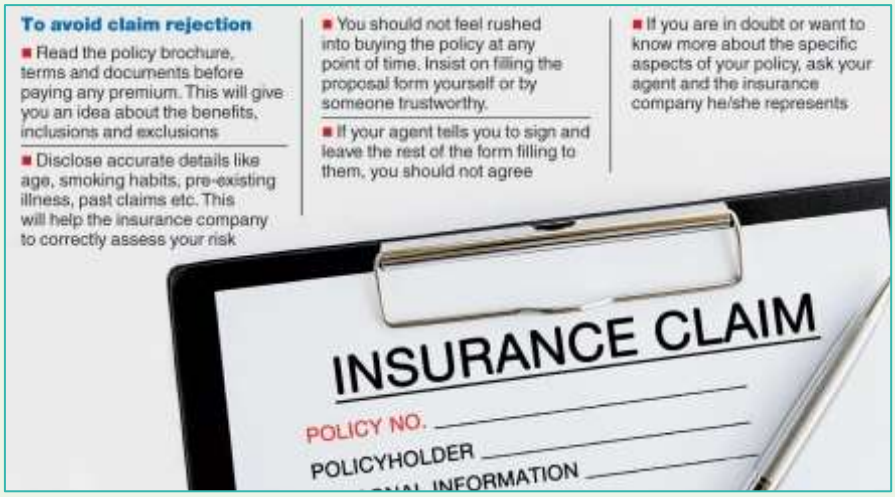
Among the many policy terms and documents that a policy buyer should go through, there is a proposal form where one has to give details such as the name, address, age proof, occupation, earnings, details of the nominee and health condition of the policy buyer.

A key question among these details is whether the policy buyer has any existing policy in effect and, if so, details such as the name of the company, the sum assured, the year of commencement of that policy and whether any claim has been made and/or declined should be mentioned.

Usually, the policy buyer fills up the form in his/her own handwriting. If a person is disabled or illiterate, the form can be filled up by the agent or any third party along with the actual signature of the policy buyer. However, policy buyers rarely fill up the details on their own. The insurance agents in their zeal to push policies ask the buyers to only sign in the relevant places and they in turn fill up the rest of the information. But the details furnished in the proposal form are critical as any wrong information could lead to claim rejection.

Court view

The Supreme Court in a verdict last month (Reliance Life Insurance Company Ltd vs Rekhaben Nareshbhai Rathod) said a life insurance company is right in refusing to pay claim on a policy if the policyholder has concealed or inadvertently failed to disclose the fact that there is an existing policy with another insurance company, even though this is in any way not "material" to the terms of the policy.



On July 10, 2009, the spouse of the respondent took a policy from Max New York Life Insurance with a sum assured of Rs 11 lakh. Two months later, on September 16, 2009, another policy with a sum assured of Rs 10 lakh was taken by the said person from Reliance Life Insurance. In the proposal form for Reliance Life, the first policy was not mentioned.

The respondent's spouse died on February 8, 2010. Reliance Life Insurance refused to settle the claim of Rs 10 lakh after his death as the policy with Max Life (Rs 11 lakh) had not been disclosed and the latter had already settled the claim. The widow claimed that the insurance agent had forced the insured to take the policy by taking his signature on a blank proposal form together with the premium in cash.

The state and national consumer redressal forum voted in favour of the widow. But the Supreme Court overturned those judgments.

A similar argument was rejected in a division bench of the Mysore high court in the V.K. Srinivasa Setty vs Messers Premier Life and General Insurance Co Ltd. In its verdict, the bench said:

"A person who affixes his signature to a proposal, which contains a statement which is not true, cannot escape from the consequence arising there from by pleading that he signed the proposal without either reading or understanding it. That is because, in filling up the proposal form, the agent normally ceases to act as the agent of the insurer but becomes the agent of the insured and no agent can be assumed to have the authority from the insurer to write the answers in the proposal form," the bench said.

It went on to say, "If an agent nevertheless does that, he becomes the amanuensis of the insured, and his knowledge of the untruth or inaccuracy of any statement contained in the form of proposal does not become the knowledge of the insurer."

Disclose to settle

Insurance industry observers noted that the apex court's judgment will encourage insurers to reject claims on this pretext and urged the buyers to provide all the relevant information to avoid any dispute.

"Generally, the buyer discloses all the material facts to the agent, but he/she may manipulate the information so that the proposal is accepted as the agent knows the underwriting criteria of the insurer," said Sudhir Jain, vice-president of the Insurance Brokers Association of India.

"It is always in the interest of the insurance company that the customer discloses all the required information in the proposal form truthfully. This helps the company to price and manage the risk better, while avoiding the hassle of claim repudiation. All insurance companies sensitise their agents to advise their customers to provide the accurate information in the proposal form at all times," said Anil Kumar Singh, chief actuarial officer, Aditya Birla Sun Life Insurance.

The need for agents

The rising number of online sales of policies raises the question whether agents are needed at all. The industry, however, feels agents will continue to be a major distribution channel for the industry.

"The industry has over 21 lakh agents. They are professional and ask the right questions, provide the correct guidance. Even with the introduction of digital and online sales, customers still feel most comfortable with a physical meeting. In the rural areas, physical presence of an agent is even more critical," said Casparus Kromhout, MD and CEO of Shriram Life Insurance Company Limited.

Officials of LIC, which has the biggest agency base in the country, said there was a robust mechanism to handle claim repudiation and scrutinize the role of its agents.

TOP

Source

SURVEY

Insurers slow to respond to emerging risks: Insurance Report 2019 – Business Standard – 22nd May 2019

There is a significant coverage gap in emerging risk areas as far as insurance in India is concerned, finds a new report. Titled The World Insurance Report 2019, the study by Capgemini and Efma names cyber security and environmental threats as some of these emerging risks.

Some of the other findings are: That insurers have been slow to respond to emerging risks, that there is a significant coverage gap in emerging risk areas, that the slow response to emerging threats has created significant coverage gaps for customers exposed to these risks and that consumers are more prepared for change than providers.

Over half (55 per cent) of the surveyed customers said they were ready to explore new insurance models, but barely a quarter (26 per cent) were investing in them. Thirty seven per cent of the customers said they were willing to share additional data in return for improved risk-control and prevention services but only 27 per cent of insurers had the capability to tap real-time data for risk modelling purposes.

Realty lure

While real estate developers are going all out to lure buyers with attractive deals and discounts, there are signs that the strategy is helping boost sales in some regions. According to the recent ANAROCK Consumer Sentiment survey, as many as 50 per cent of the buyers across the country bought homes due to attractive prices.

Hyderabad took the lead with more than 61 per cent of the buyers surveyed by ANAROCK Property Consultants in the city confirming that lower property prices made them take the plunge last year. In some other cities, the nudging factor was something else.

For example, 50 per cent of the buyers in the National Capital Region bought property due to effective RERA implementation while 58 per cent of the buyers in Kolkata were driven by lower home loan rates. Santhosh Kumar, vice chairman, ANAROCK says: "Attractive pricing, sound social and physical infrastructure development and increased office leasing activity have made Hyderabad one of the most active real estate markets in the country."

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Source

Bhubaneswar's India Protection Quotient of 36 at par with national average, a promising 1 in 3 own term insurance, reveals Max Life Survey – Orissa Dairy – 20th May 2019

Max Life Insurance, one of India's leading private life insurers, today unveiled that 78% of Bhubaneshwar owns life insurance, making it one of the more insured cities in the country. As per the 'India Protection Quotient' survey conducted by Max Life and Kantar IMRB, Bhubaneshwar stands at a Protection Quotient of 36 out of 100, just at par with the national average of 35 for urban India.

This three-dimensional survey determined policyholders' level of financial preparedness to face future uncertainties, by studying their life and term insurance awareness, ownership and primary fears, preferences and triggers when purchasing policies.V Viswanand, Deputy Managing Director, Max Life Insurance said: "By virtue of Bhubaneshwar being an emerging IT and education hub, the city ranks at par on the life insurance protection and knowledge index of our 'India Protection Survey'.

This rapidly developing city has outperformed other leading cities such as Delhi, Mumbai, Bangalore, etc., in life insurance uptake. Surprisingly, 50% of those insurance owners have term insurance, which is the highest compared to any other city in the country.

Having said that, there is definitely scope to increase the number of insured individuals in Bhubaneshwar as term insurance is the cheapest and most fundamental form of financial protection. We're certain that the survey's compelling findings will help bring about change in the underlying attitudes and overall behavior of people around life insurance."

Bhubaneshwar performs well on life insurance protection quotient and knowledge index While the Protection Quotient (the degree to which one feels protected and mentally prepared for future uncertainties on a scale of 0-100) for urban India stands at a modest 35, protection quotient of East of India stands at a relatively poorer 33.

However, Bhubaneshwar's protection quotient of 36 is more aligned with the national average and ranks the city superior on the scale in comparison to other cities such as Bangalore, Jaipur, Kolkata, Pune, etc. Additionally, with a knowledge index score of 40, Bhubaneshwar's level of awareness of insurance as a category was found to be slightly higher than that of the country.

Term insurance ownership of 40% of the total respondents in the city highest in the country, 64% of the population aware of its benefits. Against the national average of 65% life insurance ownership, the survey revealed the East India owns lesser life and term insurance (72% and 24%, respectively) when compared to south (74% and 24%), but more in comparison to the west (57% and 16%) and north (59% and 22%) zones of the country.78% of Bhubaneshwar's population owns life insurance, making it one of the more insured cities in the country. Surprisingly, term insurance ownership makes up 40% of total respondents, twice as much the national average.

Term insurance awareness also stands at a high of 64% indicating that the education hub is far ahead in comparison to India's awareness level of term insurance. City not financially prepared to deal with critical illnesses¬¬16% of the city's population believes there will be no one to support them financially if they were to be diagnosed with a critical illness, which is why 40% of the population owns term insurance.

However, only 1% realized that critical illness can prey upon the family, whereas 54% have not even thought about it.54 % of Bhubaneshwar feel that their savings would last less than a year if critical illness was to befall and 46% in the eventuality of death.

About 16% of the city's population feels they have no one to support them in the event of critical illness and 22% feel no one would support in the eventuality of death.The insurance gap between men and women in East India remains notable, saving patterns similar In urban India, the ownership of life insurance and term insurance is lower in females as compared to males. While 59% of women as against 68% men in urban India own life insurance policies and only 19% women are term insurance owners in comparison to 22% men.

The survey also pointed at a massive life insurance gap among the men and women of East India. While 67% women own life insurance as compared to 74% males, term insurance ownership among women in the region is also a higher 27% as compared to 23% men who own term plans.

The savings objectives of women in the region are also being mostly concentrated, where close to 71% women save for kids' education and 44% save for kids marriage, only 62% men save for kids education and 35% save for kids marriage. Contrary to other regions, savings for financial future, old age security a priority for millennials in East India.

The survey found that Urban Indian Millennials in the age group of 25 – 30 years are seen to spend on travel, luxury, with nearly 43% not even thinking of protection of their families. Only 44% of youth are aware of term insurance and just 17% own it. It was found that an alarming 22% of urban Indian youth do not even consider buying a life insurance policy due to other investments that they have. However, In East India, the young prioritize protection.

Millennials in the region spend more on saving for old age security (67%) or to provide for family in case of medical emergencies or death of the breadwinner (49% and 41%, respectively) as against buying a car (13%) or travelling (15%). Although, only 50% of millennials in East India are aware of term insurance and just 22% own it.

Financial security of family in case of death and fear of inadequacy of funds for treatment of critical illness among the greatest fears pushing East India to think of term insurance. The survey revealed that for more than 50% of urban Indian the biggest fears related to the demise of the breadwinner are financial insecurity and impact on their current lifestyle.

In comparison, it was found that 64% of East India's biggest fear relate to financial security of family in the eventuality of death of the breadwinner and 62% fear the inadequacy of funds for treatment of critical illness of self or within the family.

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Source

IRDAI CIRCULARS

IRDAI issued exposure draft on revision in premium rates for motor third party insurance cover for the financial year 2019-20.

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Source

Gross direct premium underwritten for and up to the month of April 2019 is available on IRDAI website.

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Source

Exposure draft on IRDAI (Regulatory Sandbox) Regulations, 2019 is available on IRDAI website.

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Source

South Korea: Motor premium rates to rise for 2nd time this year – Asia Insurance Review

Non-life insurance companies in South Korea are looking to hiking car insurance premiums on the back of deterioration in the loss ratio. This will be the second increase in motor premium rates following hikes in January this year.

Market leader Samsung Fire & Marine said, "We will raise auto premiums by 1.5% in the first week of June." Samsung's combined ratio for the first quarter of this year was 103.6%, up 1.8 percentage points from the corresponding period of the previous year.

Other insurers are expected to raise motor premium rates too, reported Maeil Business. Among them, KB Insurance plans a 1.6% increase in early June. Hyundai Marine & Fire, which has yet to announce its position, is expected to raise premiums.

Another factor explaining the imminent premium increases is rising costs due to the revision of the standard terms and conditions of insurance policies as a result of a decision by the Supreme Court. Earlier this year, the Supreme Court raised the expected legal maximum age for physical work from 60 to 65.

According to a report in The Korea Times, the insurance industry is affected the most directly by the court decision, because in car insurance, compensation is calculated with the age set at 60. If the age is pushed up to 65, the compensation amount would increase.

TOP

Source

Taiwan: Life insurers to face tougher regulations – Asia Insurance Review

The Financial Supervisory Commission (FSC) is set to impose stricter regulations on domestic life insurers in Taiwan from the second half of this year, which includes preventing companies from promising unrealistically high returns for their savings products, reported the Taipei Times citing an announcement from the FSC yesterday.

Other measures set to be introduced include setting a new lower limit on the death benefit-to-policy value ratio, as well as requiring insurers with low equity-to-asset ratio to increase their capital.

The announcement was made after a recent three-hour long meeting between FSC Chairman Wellington Koo and 22 life insurers in the market. The parties discussed ways to resolve major problems facing insurers such as overheating in the insurance sector, low equity-to-asset ratios and the implementation of the new International Financial Reporting Standards 17 (IFRS 17).

Major insurers who attended the meeting include China Life Insurance chairman Alan Wang, Fubon Life Insurance chairman Richard Tsai and Cathay Life Insurance chairman Huang Diao-kuei.

According to Mr Koo, local life insurers have seen their combined annual premium income increase by over NT$3tn($95.15bn) over the past three years. Out of this amount, insurers spent NT$2tn on investments in a bid to generate enough profit and provide high returns to policyholders. However, when

insurers make overseas investments, they become vulnerable to fluctuating exchange rates and interest rates.

With insurers reporting a low average equity-to-asset ratio of 5.85% at the end of March, Mr Koo stressed the need for insurers to prepare and set aside a larger special reserve before adopting the IFRS 17.

TOP

Source

Asia: Composite pricing increases in 1Q2019 - Asia Insurance Review

In Asia, insurance pricing in the first quarter of 2019 increased by 0.4%, marking the seventh consecutive quarter of relatively minor pricing movements., according to the latest Marsh Global Insurance Market Index.

Other trends noted in Asia include:

- Property pricing increased by 0.6%, only the third quarterly increase in four years.
- Casualty pricing declined 0.4%, continuing a trend toward stable pricing following several years of moderate decreases.
- Financial and professional liability pricing generally increased, with the composite up 0.2%. This marked the first back-to-back quarterly increases in more than six years. Financial and professional liability pricing was influenced by the deteriorating global market and carriers' efforts to achieve pricing adequacy while reducing capacity.

Global
Globally, commercial insurance prices rose by 3%, on average, in the first quarter of 2019, marking the sixth consecutive quarter of increases, according to the Index. Composite pricing in the first quarter increased in all global regions for the second quarter in a row, driven by rate change in property and directors and officers (D&O) coverages.

Regionally, Pacific had the largest price increases in the index (>10%), a trend that has continued for eight quarters. The UK and Continental Europe both reported average price increases of 2% or higher. Insurance pricing in the first quarter of 2019 in the US increased by 1.1%.

Overall, the insurance market remained stable, with prices increasing or decreasing within a relatively narrow band across most products and regions.

The Marsh Global Insurance Market Index is a proprietary measure of commercial insurance premium pricing change at renewal, representing the world's major insurance markets and comprising nearly 90% of Marsh's premium. The pricing change captures year-over-year pricing movement, measured quarterly. The pricing change metrics are based on a combination of statistical data and surveyed opinions from Marsh placement leaders worldwide.

TOP

Source

Australia: Nat CAT costs hits performance of general insurers in Q12019 - Asia Insurance Review

Australia's general insurance sector recorded a 32.4% drop in underwriting results to A$2.8bn, due to claims from the Sydney hailstorm and Townsville flood as well as a strengthening of claims reserves in professional indemnity and mortgage classes.

The latest quarterly general insurance statistics from the Australian Prudential Regulation Authority (APRA) revealed that net incurred claims expense stood at A$23.2bn ($15.9bn), which marked a 14.9% increase from 1Q2018.

However, the results were offset by a significant increase in investment income due to unrealised gains on insurers' fixed interest investments that resulted from falling bond yields. In fact, investment income increased by 42.2% and stood at A$3.1bn. At the same time, net earned premium for the last quarter was A$34.5bn, marking an increase of 6.4%.

APRA's quarterly general insurance performance statistics publication comprises detailed statistics at a class-of-business level, a breakdown of operating income and expenses as well as more granular solvency information. Data in this publication are prepared from individual insurer accounts and represent the total operations of Australian authorised insurers.

APRA is the prudential regulator of the financial services industry and supervises general insurers under the Insurance Act.

TOP

Source

Global: Customers demand insurance products that address coverage gap & emerging risks - Asia Insurance Review

Policyholders are increasingly concerned that their insurance coverage has become insufficient for emerging risks, from cybersecurity to environmental threats, according to the World Insurance Report 2019 published by Capgemini and Efma last week.

At the same time, insurers are less ready for change than their customers, most of whom want more comprehensive and dynamic coverage, says the report.

At the same time, a significant opportunity exists for insurers to leverage technology and partnerships to get ahead of macro trends and become more proactive partners to their customers.

Key findings of the report include:

Insurers have been slow to respond to emerging risks

The report identifies five macro trends that are creating emerging risks for insurance customers and their businesses: disruptive environmental patterns, technological advancements, evolving social and demographic trends, new medical and health concerns, and business environment changes. Yet most insurers have been slow to respond to these trends and equip customers for them. Under 25% of business customers across all geographies, and less than 15% of personal policyholders, feel they have sufficient coverage to insure against any one of the emerging risks driven by these macro trends. Fewer than 40% of life and health insurers said they have built a pipeline of new products to cover emerging risks comprehensively.

There is a significant coverage gap in emerging risk areas

The slow response to emerging threats has created significant coverage gaps for customers exposed to these risks. The report estimates that 83% of personal insurance customers have medium or high exposure to cyberattacks and to outliving their savings, yet just 3% and 5% respectively are comprehensively covered against these eventualities. Among business customers, 81% are exposed to escalating employee healthcare costs against which just 17% are well covered; 87% are at risk of cyberattacks with less than 18% comprehensively insured; and almost 75% are threatened by rising natural catastrophes, for which just 22% are effectively covered.

Consumers are more prepared for change than providers

As the insurance landscape shifts, customers are showing greater readiness for change than their insurance providers. Over half (55%) of customers said they are ready to explore new insurance models, but barely a quarter (26%) of insurers are investing in them. While 37% of customers said they are highly willing to share additional data in return for improved risk control and prevention services, only 27% of insurers have the capability to tap real-time data for risk modelling purposes.

Insurers need to innovate, and become partners and preventers

Insurers must respond to emerging threats, and changing customer expectations, by embracing new technology and partnerships. Risk assessment capabilities can be significantly enhanced through deployment of machine learning, artificial intelligence and advanced analytics, and effective collaboration with InsurTech providers. Progress in these areas has been mixed: a majority (57%) have leveraged AI, machine learning and advanced analytics, but only 29% have implemented automated risk assessment, and just 20% real-time insight generation from IoT devices. According to the report, technological progress also needs to be matched by a shift in attitudes. Where insurers have traditionally seen themselves as a payer, they need to evolve into the parallel roles of partner and preventer, working more closely with customers to mitigate risks and provide on-demand services.

Mr Anirban Bose, CEO of financial services at Capgemini and member of the group executive board, said, "Emerging risk trends and rising customer expectations are dramatically changing the landscape for insurance, and providers must be agile in how they respond.

"This research shows a coverage gap in areas of emerging risk, but also highlights an important opportunity for insurers. Those that can evolve their products through technology, collaborate with innovators, and think of themselves as partners and preventers to their customers, stand to benefit the most."

Mr Vincent Bastid, secretary general of Efma, said, "This research shows that the future for insurance will be partnership-centric. "Insurance providers need to collaborate with partners who offer high levels of expertise in areas from AI to advanced analytics. Simultaneously, they must partner more closely with their customers to provide the more responsive, demand-driven service many are seeking."

The World Insurance Report 2019 covers all the three broad insurance segments? life, non-life, and health insurance. This year's report draws on research insights from two primary sources: the 2019 Global Insurance Voice of the Customer Survey and 2019 Global Insurance Executive Interviews. Together, these sources cover insights from 28 markets: Australia, Belgium, Brazil, Canada, China, Finland, France, Germany, Greece, Hong Kong, India, Italy, Japan, Mexico, the Netherlands, Norway, Philippines, Poland, Portugal, Singapore, South Africa, Spain, Sweden, Switzerland, Turkey, the UAE, the UK, and the US.

Capgemini is a global consulting, technology services and digital transformation firm. Efma, headquartered in Paris and established by banks and insurers, is a global non-profit organisation which facilitates networking between decision-makers. Over 3,300 brands in 130 countries are Efma members.

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Source

South Korea: Life insurers see improving product mix & stable capitalization - Asia Insurance Review

Moody's Investors Service says in a new report that its stable outlook for Korea's life insurance sector is supported by an improving product mix and stable capitalisation, even as demand for life insurance declines.

"Upcoming tighter regulations will continue to drive insurers to shift away from traditional savings-type and annuity products towards protection and variable-type products," said Mr Young Kim, a Moody's

analyst. “The growth in particular in protection-type products will support underwriting performance, as these products carry higher margins and are less sensitive to interest rates than savings-type products, although they also incur higher acquisition costs,” he added.

Nonetheless, this product shift, together with subdued economic growth, will lead to lower demand for life insurance products.

Upcoming changes to the local risk-based capital system will further tighten the recognition of interest-rate, credit and market risks and promote stronger capital management in the medium term. This will improve the ability of the insurers to withstand distress, but will also reduce their reported capital metrics.

Moody's expects the insurers will maintain a steady pace of capital issuance in the medium term to keep capital metrics stable.

Meanwhile, low domestic interest rates continue to drive overseas investment. These investments are raising foreign exchange risk, as high US dollar hedging costs have led insurers to use short-term hedging instruments, in turn exposing them to rollover risk.

However, this risk is somewhat mitigated by the recent tightening of regulations on overseas investment. The overall risk from overseas investment — mainly fixed income and loan portfolios — will remain conservative and manageable.

TOP

Source

Hong Kong: Health insurance market teems with opportunities – Asia Insurance Review

High out-of-pocket payments by patients at private hospitals and overwhelming demand for public health care underscores the need for further development of Hong Kong's health insurance sector, according to a new AM Best market segment report.

With the recently launched Voluntary Health Insurance Scheme (VHIS), which encourages individuals to utilise insurance protection, and the subsequent regulatory approval for more than two dozen insurers to launch VHIS insurance products, the uptake of health insurance in Hong Kong should grow significantly.

In its report titled, “Growth Opportunities Abound in Hong Kong’s Health Insurance Market,” AM Best notes that while insurers are cognisant of and keen to leverage the growth potential, they must also be mindful of challenges affecting profitability and sustainability of the health insurance business.

Total non-life gross premiums from direct medical insurance expanded robustly, with year-over-year growth rates rising to 11% from 4% in a five-year span (2013-2017). As direct medical products account for approximately three-quarters of the accident and health (A&H) line, A&H business now represents the largest share of domestic non-life gross premiums written, at 33% as of 2017.

Despite the strong growth momentum, the A&H line of business has shown declining profitability. A&H underwriting performance has remained close to breakeven and the underwriting margin has declined sharply. Additionally, the expense ratio on direct medical insurance has continued to edge upward, to 21.3% in 2017 from 18.9% in 2013.

Intense competition on A&H business, along with rising demands for greater transparency and standardised product designs, will continue to exert pressure on underwriting profitability. AM Best considers it important for the industry to embrace a lean structure and adjust marketing and distribution strategies to lower acquisition and operational costs. At the same time, the VHIS plans present market

players with an opportunity to strengthen their customer base, while gradually paving the way to upsell more profitable products.

AM Best believes that insurers will pay close attention to consumer sentiment toward VHIS, and adjust their strategies accordingly. In addition, smaller market players that can find sustainable ways to refine cost structures and enhance operational efficiency while maintaining disciplined underwriting strategies likely would experience better-than-average profitability in the A&H line. InsurTech also can play an increasingly influential role in insurance companies' customer acquisition, sales and cost management strategies.

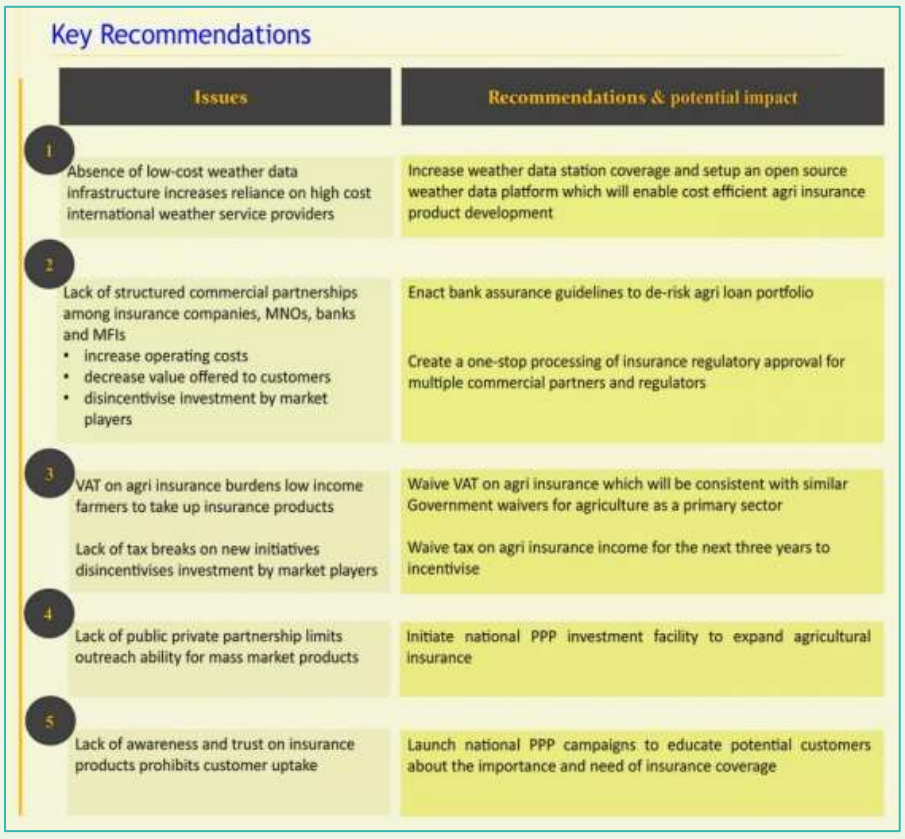
"The need to raise public insurance awareness remains critical in addressing social and economic issues stemming from Hong Kong's fast-aging society," said Mr James Chan, AM Best senior financial analyst. "In turn, companies that adopt a corporate culture that promotes innovation are more likely to reap tangible benefits—such as lower expense ratios, greater brand recognition and stronger customer loyalty—and maintain a competitive edge over the long term."

TOP

Source

Weather index-based insurance for mitigating agricultural risks in Bangladesh – The Daily Star – 19th May 2019

Business Finance for the Poor in Bangladesh (BFP-B) in association with the Green Delta Insurance Company Limited and The Daily Star organised a roundtable titled "Weather index-based agriculture insurance" on May 2, 2019. Here we publish a summary of the discussion.



Key Recommendations

	Issues	Recommendations & potential impact
1	Absence of low-cost weather data infrastructure increases reliance on high cost international weather service providers	Increase weather data station coverage and setup an open source weather data platform which will enable cost efficient agri insurance product development
2	Lack of structured commercial partnerships among insurance companies, MNOs, banks and MFIs • increase operating costs • decrease value offered to customers • disincentivise investment by market players	Enact bank assurance guidelines to de-risk agri loan portfolio Create a one-stop processing of insurance regulatory approval for multiple commercial partners and regulators
3	VAT on agri insurance burdens low income farmers to take up insurance products Lack of tax breaks on new initiatives disincentivises investment by market players	Waive VAT on agri insurance which will be consistent with similar Government waivers for agriculture as a primary sector Waive tax on agri insurance income for the next three years to incentivise
4	Lack of public private partnership limits outreach ability for mass market products	Initiate national PPP investment facility to expand agricultural insurance
5	Lack of awareness and trust on insurance products prohibits customer uptake	Launch national PPP campaigns to educate potential customers about the importance and need of insurance coverage

Feisal Hussain, *Team Lead, BFP-B*

Weather index-based insurance is one of BFP-B's 30 live innovation-investments in Bangladesh. We do rigorous impact assessments to see how the business models are faring. We have completed the assessment of the weather index-based insurance model and have identified the opportunities and challenges the business model presents for the insurance industry, the government of Bangladesh and other private sector actors. One of the crucial challenges is that investments in business models to support agricultural insurance is being held back, given complex and time-consuming regulatory approvals are required across multiple regulators. For example, viable business models require partnerships between insurance companies (regulated by IDRA) and channel partners such as MNOs (regulated by BTRC), MFIs (regulated by MRA), payment service providers (regulated by Bangladesh Bank), and weather data providers (regulated by the meteorological department). Can we have a one-stop shop (OSS) for insurance companies through for instance, BIDA,

where investors in agricultural insurance can secure approval for all regulatory requirements conveniently, efficiently and predictably?

Farzanah Chowdhury, *MD & CEO, Green Delta Insurance Company Limited*
Agriculture is one of the key driving forces of our economy. More than 72 million people are engaged in the agriculture sector. Its contribution to GDP is around 14 percent. In 2015, we started a pilot project with International Finance Corporation (IFC) to mitigate the risk of financial loss in the cultivation process, thus helping the farmers in risk coverage. IFC has helped us create historical weather data grid and Bangladesh Meteorological Department (BMD) has also supported us by providing historical data from 1981. In 2016, we joined hands with BFP-B. We have covered more than 15,000 farmers through awareness and policies who possess 5,000 acres of land and settled claims of 3,200 farmers till date. One of our unique features is quick claim settlement with an easy and transparent process. The momentum has already been created but we need to create more awareness not only among farmers but also among seed companies, NGO/MFI, banks, input retailers and policymakers about weather-based insurance products. We need robust support from the Ministry of Agriculture, and the government should provide incentives to private organisations to invest in this critical sector. We believe that agri insurance will be the game changer in the insurance sector. We are using the satellite data to track the weather conditions of the insured areas but currently we are dependent on international weather data service provider which is very costly. If we can develop a platform where researchers, practitioners and development partners work together, we can cut down the cost of weather data procurement to one-third of the present cost.

Ali Tareque Parvez, *Senior Vice President, Green Delta Insurance Company Limited*
The weather index is basically a weather parametric index with a predetermined trigger point based on historical weather data. We have historical weather data since 1981 coupled with satellite data. We analyse this data, prepare the term sheet and take up coverage collaborating with our distribution partners and finally settle the claims. It is a comprehensive business model that combines multiple channel partners to reach the marginal farmers. We customise our insurance products according to the requirements of customers, so that it is beneficial for their investments. Our system operates in a way that avoids the need for on-site damage verification on a case-by-case basis and eliminates the need to collect payout claims from farmers.

We have interpolated data stations in each 10 square kilometers which inform us about the weather in specific locality. Currently, we have more than 1,477 such stations. So far, we have covered perils like droughts, unseasonal rainfall, heavy rain, cold wave, humidity, high temperature etc. We have provided insurance for various cash crops such as industrial potatoes, vegetables, hybrid rice and so on.

In 2016, and 2017 we insured against heavy rainfall. According to our offer, farmers could claim payouts if the rainfall was of 16mm. During the period the rainfall was 125mm. We settled the farmers' claims fast, and it helped us gain confidence of the farmers. We arranged a programme in the presence of the then State Minister for Finance and Planning, MA Mannan and IDRA Chairman and local authorities and handed over the claims to the affected 1,000 farmers. In 2018, there was an unprecedented cold wave and we settled claims of 2,000 farmers.

Through Value Added Services, enrolled farmers get a weather forecast for seven days and crop advisory in Bangla. We have also launched a toll-free number where farmers can call for any agriculture-related queries.

We are trying to cover new areas and new cash crops. For that, we have partnered with distinguished stakeholders such as Info Corp, Syngenta, CARE Bangladesh; there are many more on the pipeline to broaden our service spectrum. If we get adequate support from the government, we can achieve highest coverage of weather index- based insurance products. We are also working on Flood Index Based Crop Insurance in the northern part of Bangladesh and in the haor region with the support of Ministry of Finance, IDRA & SBC. Future technology driven products such as satellite products, germination coverage, bundle with service providers etc. need to be introduced. We should also cover natural disasters such as hailstorm and flash flood. However, as Bangladesh has different weather calamities and

parameters like temperature, humidity, sunshine hour, only satellite data will not work. We need to track different types of weather parameters to successfully implement agri insurance across the country.

Muhymin Chowdhury, *Deputy Challenge Fund Manager, BFP-B*
We wanted to test whether there is a need for weather index-based insurance. After doing the end-line assessment, we saw that there is a strong need for such a product, and it should be replicated in the market. We have also discovered how insurance companies can partner with field-level players such as farmers' hub and agro-input retailers. Another key finding is that farmers are keen to pay for insurance if the product can address their pain points.

When we piloted this project most of the heavy-lifting was done by Green Delta as there is a lack of an appropriate ecosystem to support agricultural insurance market. Due to the absence of structured crop data, Green Delta had to develop crop data through engaging farmers and the Ministry of Agriculture. Green Delta had to undertake a lot of awareness activities to promote the benefits of having weather index-based insurance.

There is a willingness to deliver the value, but this willingness is restrained by the high-capital expenditure and operational cost of launching these products.

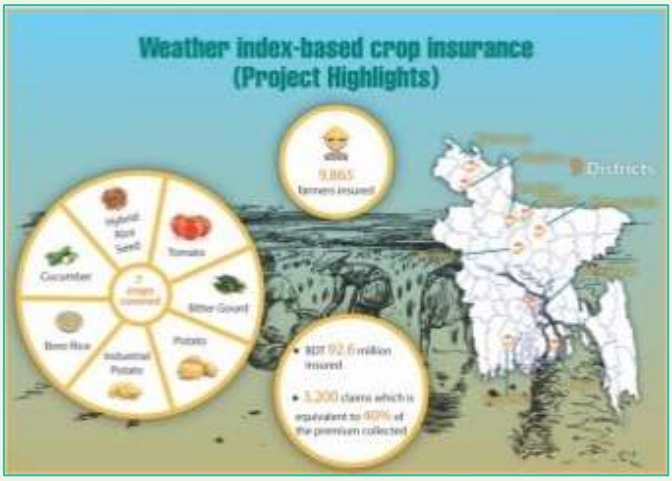
One of the major cost components of launching weather index-based insurance is weather data (37 percent of the total cost of launching a product). Bangladesh Meteorological Department's infrastructure is not available across the country which limits the ability to get government-supplied data. Hence there is an increasing reliance on international weather service providers which is pushing up the cost and limiting the value of the insurance product.

There is a misunderstanding about the market potential. The agricultural insurance market is twice the market size of e-commerce. If you look at the total portfolio of non-life insurance companies in Bangladesh, the agri-insurance market would be comparable to the entire sector. There is huge potential of this agri-insurance sector, and the benefit can only be achieved if we can ensure strong coordination between the insurance industry and other relevant stakeholders. There is also an absence of competition and cooperation within the insurance sector.

Shubasish Barua, *Head of Product Development & Executive Vice President, Green Delta Insurance Company Limited*
India has made it mandatory for all the insurance companies to do 7 percent business through crop insurance. It has proved to be successful in promoting agri-insurance and supporting farmers. Bangladesh can learn from the example.

As per insurance Act 2010 the non-life insurance companies are not allowed to have any corporate agent agreement with any corporate agent. Now if any MNO is interested to provide crop insurance, and deduct the premium from usage, they won't be able to do it as they are not the authorised premium collector/Agent. Same is applicable for MFIs as agent. We need to reform the law so that non-life insurance companies can get the same opportunity as life insurance companies. Moreover, if an insurance company wants to be a content provider to an MNO, they need to have TVAS (Telecom Value Added Service) license from BTRC. An insurance company is not allowed to obtain that license. In that case, they need a fourth party to work as a TVAS content provider which will increase the cost further. IDRA may support us in increasing the insurance awareness and reaching the mass people with crop insurance by allowing an MoU agreement between NGO/ MFI/MNOs and insurance service providers.

Dr. Shameem Hassan Bhuiyan, *Consultant, World Bank*
If we can build a strong weather database and necessary infrastructure, we can lower the cost. We have already established 20 weather stations in Bangladesh. But that is not enough for collecting data on the whole country. A weather station can cover only a 20 km radius. If the private sector joins hands with us, we can build a strong weather database and necessary infrastructure for the whole country.



The main component for weather index based insurance is real-time location-specific data, not forecast. As per World Meteorological Organization (WMO) recommendations, one Automatic Weather Station (AWS) is required for covering a 10km radius for ensuring accurate and transparent weather data. Through AWS database, every farmer can see the current weather situation.

One-stop service (OSS) is a new phenomenon. It has already been established in some sectors such as Bangladesh Investment Development Authority (BIDA) and Bangladesh Economic Zones Authority (BEZA). The industry-promoting agencies have all opened OSS to keep pace with the current demand for OSS.

Though our insurance industry is an emerging sector, it still has a long way to go. Our insurance companies have less than one percent coverage while other countries have approximately five percent coverage. Therefore, attention is required to increase the coverage in our country. The government is very accommodating and keen for the insurance sector to grow.

Md. Arafat Hussain, *Challenge Fund Manager, BFP-B*
In Africa there are some AWS solutions that costs less than USD 200. In these AWSs, four or five sensors are combined in a small device. We can easily adopt this solution in Bangladesh.

Ahmed Ali, *Co-founder, MARS Limited*
We provide weather data for almost all areas of the country. Our forecast accuracy level is more than 93 percent. We work with tea estates, tobacco companies and farmer communities. We have bought two AWS (tile basis) from Canada, each of which cost TK 25,000. If we set it up in Khulna, we can monitor data from our office.

AKM Iftekhar Ahmad, *Consultant, Green Delta Insurance Company Limited*
The success story of crop insurance in India is due to patronisation and cooperation of the government of India. Bangladesh's crop insurance also requires the support and patronisation of the government. All the loan giving agencies including microfinance in agri sector needs to be brought under insurance. This will generate higher premium and encourage farmers to join the insurance umbrella.

M. A. Karim, *Deputy Manager, Sadharan Bima Corporation*
Sadharan Bima Corporation has tested crop insurance on potato and rice in three areas. It has been found scalable and viable. Also, in the SBC project, 20 AWS (Automatic Weather Station) has been installed in two districts. It is high time for Bangladesh to scale up crop insurance, and a common platform is required for weather data support.

Md. Moneruzzaman, *Head of Pricing, Banglalink*
We can support any positive initiative through our distribution system. Currently, we are working with BRAC to distribute different products in deep rural areas.

Gokul Chand Das, *Member, IDRA*
The Insurance Act states that it is not possible to do insurance business in Bangladesh without obtaining license from IDRA. Many countries have policies to cover the loan book of the borrower by non-life

insurance companies. We simply need to collaborate with the banks. When banks roll out their credit, insurance companies can be there to provide insurance.

There are some differences in the types of crop insurance services provided by the insurance providers in our country. For instance, the finance minister directed us to have crop insurance in the low-lying haor areas of Bangladesh. But, companies such as Green Delta Insurance Company and SBC Insurance don't have experience of working in these vulnerable areas which badly require crop insurance or catastrophe insurance. If we want to expand these types of insurance throughout the country, we need to create a win-win situation for both the insurance providers and customers.

Afsana Islam, *Deputy Team Leader, Growth & Private Sector Development, DFID*
The importance of agriculture is critical for our economy. We must find ways to provide funding to our farmers. Bangladesh is committed to achieving the SDGs. In this context, one of our goals is to provide people with appropriate financial services. This doesn't involve providing these services solely through banks or MFIs. We need to ensure that they don't get adversely affected by losses arising from instances like natural calamities.

Though insurance is an important product, its penetration is quite low in our country. So, the question is, how can we make the insurance market more attractive to the users? And how can we ensure that we provide such services to those who need it the most?

The current market requires a one-stop shop(OSS) for demand-driven solutions. I think FID can take the central authority by being the regulator or reporting body of all the regulators; they can take the driving seat to provide solutions which will benefit everyone in the market.

Ajit Kumar Paul, *Additional Secretary, FID, Ministry of Finance*
There is a committee known as the co-ordination committee chaired by the central bank governor. A meeting is held on a quarterly basis with Bangladesh Bank, other banks, insurance sector, micro-credit regulatory authorities, registrars of joint stock companies and some other coordinators and regulators. The issue of OSS can be raised in the forum.

IDRA has been instructed to implement agriculture insurance in the haor areas. We need to focus on supporting people suffering in haor areas due to such natural disasters and the Government is taking various steps to help them. We are also holding talks with multiple insurance companies in this regard.

The government has implemented the VAT law to accommodate people. I would request the organisations present here to make recommendations as to how we can be more accommodating and can resolve the VAT issues. All the concerns will be adjusted in the upcoming budget.

TOP

Source