भारतीय बीमा संस्थान
INSURANCE INSTITUTE OF INDIA

INSUNEWS

Weekly e-Newsletter

26th Jan – 1st Feb 2019

Issue No. 2019/5

QUOTE OF THE WEEK

"To become 'unique,' the challenge is to fight the hardest battle which anyone can imagine until you reach your destination."

- A. P. J. Abdul Kalam

INSIDE THE ISSUE

INSURANCE INDUSTRY

What the insurance industry expects from Interim Budget 2019 - The Economic Times – 31st December 2019

We all are eagerly waiting for the annual budgetary plan for the next financial year which will be shared by the BJP-led NDA government in about a week from now. And with Lok Sabha Elections round the corner, it will be an uphill task for the current government to meet all the possible expectations of the taxpayers in this year's union budget which will be an Interim Budget.

In his recent speech, the Union Minister of India, Arun Jaitley made it quite clear that this Interim Budget exercise will deviate from the general practice of providing a simple Budget, and would rather focus on providing maximum help in all the required sectors. The finance minister through his speech also indicated that this year's budget will be significantly driven by economic issues that require immediate resolution – a strong indication that the government in power will use its last budget to woo the taxpayers before the upcoming General Elections. Like all other sectors, the many promises made by Arun Jaitley have generated significant interest amongst the insurance industry as well which is expecting some positive tax benefits and regulatory framework in the forthcoming Budget.

Insurance industry experts believe that this year's budget speech, to be delivered by the Finance Minister, Piyush Goyal will be very important for the insurance sector because, in the year 2018, the industry witnessed several important announcements and regulatory changes. The NDA-lead central government took numerous key decisions in favour of the general public including the inclusion of mental illness in health insurance, changes in rules for motor insurance, and the successful merger of 3 PSU non-life insurers.

Health Insurance Industry

No doubt, many new laws and policies aimed at supporting the governance of the health system in India were introduced by the different governments; unfortunately, most of these laws were not implemented systematically. In the coming budget, the health insurance industry is one the most important sectors that need immediate consideration. As per industry experts, there is an immediate need to spread awareness about the importance of health insurance amongst the people, especially the lower and middle class. Insurers believe that enhancing the tax rebate under Section 80D from the current value of Rs. 25, 000/- to Rs. 150, 000 can be a great start along with a waiver of GST which is currently 18%.

Many insurers are even demanding that the way motor insurance is mandatory under the Motor Insurance Act; health insurance must also be made mandatory by passing a required law. Another major expectation of health insurance industry from the Interim Budget is giving consumers the ability to pay level premiums up to 5 years with multiple payment modes including monthly, quarterly, half-yearly, and limited pay like that in life insurance.

Life Insurance Industry

The current biggest concern surrounding life insurance industry is the lack of required awareness about the true purpose of life insurance in India. What a recent report states is that with a population of more than 133 crore, India's life insurance penetration rate is even less than 3% of the entire GDP. To address this issue, the life insurance companies are demanding a few alterations in the regulatory system in the upcoming Interim Budget. The insurers are expecting a separate section under the Income Tax Act (over

and above 80C), giving tax rebate to the people on premium paid against Pure Life Insurance plans. Also, a GST waiver is demanded on Pure Protection Plans that include both Term Life and Health.
Yet another important change expected from the Interim Budget is in the Unit Linked Insurance Plans - long-term investment-cum-insurance products. Some smart initiatives expected from the government is the reduction of the Lock-in period in ULIPs to 3 years from 5 years (comparable to ELSS) and a GST waiver of charges which is currently 18%. All these regulations are expected to play a major role in the immediate growth of the life insurance sector.

Motor and Travel Insurance Industry
Luckily, as per a recent indication by the Insurance Regulatory and Development Authority of India (IRDAI), the insurance premiums of two-wheelers and four-wheelers may soon come down as from the financial year 2020-21, IRDAI may discontinue the regular practice of fixing the annual premium for third party (TP) insurance for motor vehicles. Like all other insurance sectors, motor and travel insurance industries are also expecting a waiver of the GST from the insurance products being sold by the insurers. Doing this will motivate more and more people to take adequate insurance cover.

Angel Tax
Another major concern of the start-ups is receiving income tax notices from the income tax department on the angel funding they received during various series of funding. In general, Angel tax is a term that is used to refer to the income tax payable on capital raised by start-ups via issue of shares. Given the sheer amount of opposition to the angel tax, in this year's Interim Budget, the entrepreneurs and angel investors are hopeful of a positive change. The investors and entrepreneur are expecting abolition of the tax, reduced taxation rates and/or better clarity on the meaning tax slab.

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Less than a minute for issuing policies and settling claims - Financial Chronicle – 29th January 2019

It will take just less than one minute to issue a policy or settle a claim. Within a year's time, most of the insurance providers will be able to make this promise. Almost all the insurers are building artificial intelligence and machine learning solutions into their processes to become faster and more efficient.

"Insurance companies are working on deploying AI and machine learning solutions into their processes. In a year or year-and-half I am confident that many insurers will be able to issue medical, travel and motor policies and settle the claims as well within a minute," said Vinay Kumar Sankararapu, CEO and co-founder of Arya.ai, an artificial intelligence solutions provider for multiple industries.

Arya.ai has already helped ICICI Lombard start issuing cashless health claim settlement in a minute. It is in the process of extending this to reimbursement claims. Arya.ai is also working with a few other insurance companies for deploying these technologies.

"ICICI Lombard is the first Indian non-life insurance company to pioneer the use of artificial intelligence and machine learning in health claim processing. Understanding medical diagnosis is a significantly complex activity for which we have deployed Arya's AI technology leading to reduced cashless claim request approval time from the earlier average of 60 minutes to under a minute now," said Girish Nayak, ICICI Lombard's chief-service, operations and technology.

Reimbursement of medical claims currently takes as average 25 to 30 days. Arya is working on the technology that will enable reimbursement settlement well within a minute if the supporting data is

available in the electronic format and are uploaded to the system. The same would be the case in motor and travel insurance.

Bajaj Allianz' Travel Ezee takes just a few minutes to disburse compensation for flight delay and the company itself intimates the customer about this. Further, 'Motor On the Spot' has been able to bring down claim settlement time from a few days to a few minutes.

According to Sankararapu, even in case of life insurance it would become possible to settle a claim within an hour, if the claim is authentic and does not require any further investigation. AI and machine learning companies are working mainly on three fronts--on policy issuance, detection of fraud and claims settlement. While the technologies will improve efficiencies in detecting fraud, they will make other two processes faster.

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IRDAI REGULATION

Make provisions for beleaguered IL&FS exposure: Irdai to insurers - Business Standard – 1st February 2019

The Insurance Regulatory and Development Authority of India (Irdai) has asked insurers to make provisions for their exposure to the beleaguered IL&FS group because the write-off option is not there.

They have to make provisions because those exposures cannot be written off, Irdai Chairman Shubash Chandra Khuntia said on the sidelines of the release of the handbook on general insurance on Thursday.

The regulator in September last year had asked insurance companies to declare their exposure, both equity and debt, in the IL&FS group.

Moreover, the Irdai chairman had cautioned insurance companies on the risks associated in investing in low-rated debt instruments. The Irdai has issued norms for provisioning sub-standard assets. Under write-off, the company eliminates assets from the books while provisioning maintains that asset on the books and creates a provision on the liability side, said Kedar Patki chief financial officer, IDBI Federal Life Insurance.

While norms set the minimum requirement for provisioning, companies may take a more conservative view and provide for more than what is required by regulation, Patki added. Some IL&FS group entities defaulted on debt repayments, which caused a liquidity freeze in the non-banking financial company (NBFC) sector in September last year.

The company is sitting on a debt of more than Rs 90,000 crore. Life Insurance Corporation is the largest shareholder in the IL&FS group, holding 25.34 per cent. The erstwhile senior executives of the company have been dragged to the National Company Law Tribunal by the ministry of corporate affairs over allegations of mismanagement.

Among private insurers, IDBI Federal Life Insurance has an exposure of Rs 20-25 crore to the IL&FS group. It is not accurately known how much insurance companies have exposed themselves to the IL&FS group. Khuntia also expressed concern over commissions insurance companies pay motor insurance service providers (MISPs) because they were higher than what the regulator stipulated.

"Whenever it is coming to our notice, we are taking action. We have also done some focused inspection of MISPs, and we are watching the market very carefully for violations," Khuntia said.

The regulator had expressed concern last year that original equipment manufacturers (OEMs) were exercising undue influence both on the insurance intermediary and automobile dealers who have become MISPs without accountability.

Also, they had capped the payments made by insurers to agents and dealers of cars and two-wheelers and brought them under its regulatory framework as MISP.

Khuntia said, after the GST on third party insurance was reduced to 12 per cent from 18 per cent, the regulator was in consultation with the GST Council on reducing the tax rate on property insurance in vulnerable areas.

Khuntia also touched upon the mis-selling aspect of the insurance business and asked industry players to devote more time to underwriting products.

He asked insurers to speed up the claim settlement process. As the non-life space is under-penetrated in India, the chairman expressed hopes that cyber security insurance would be a big opportunity for general insurers in the future to capitalise on.

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Aadhaar not mandatory to buy insurance policy – The Hindu – 30th January 2019

Insurance regulator IRDAI has advised insurers not to mandatorily seek Aadhaar and PAN/Form 60 from customers, existing or new, for KYC (Know Your Customer) purpose.

It, however, allowed insurers to accept Aadhaar card as one of the documents for establishing identity, address of the customer subject to certain conditions that presumably are being stipulated to guard against misuse of the information.

The insurers can accept Aadhaar as one of the documents for KYC, only when the same is offered voluntarily by the proposer/policy-holder.

This would apply to the physical copy of e-Aadhaar, masked Aadhaar and offline Aadhaar XML.

'Ensure masking'

The Insurance Regulatory and Development Authority of India (IRDAI), said insurers, however, "will under no circumstance do the authentication either using e-KYC facility or the yes/no authentication facility of UIDAI."

Also, it directed the insurers to ensure that the first eight digits of the Aadhaar number are properly/appropriately masked. "At no point in time more than last four digits of the Aadhaar number of any individual should be stored by the insurers in physical or digital form," a circular issued by IRDAI on Tuesday said.

The advisory to the insurers came in the backdrop of a Supreme Court judgment of September, 2018, that held as unconstitutional making Aadhaar and PAN/Form 60 mandatory for availing financial services, including insurance. While laying down the conditions, under which all life and general insurers, could use Aadhaar, the regulator withdrew its circular, permitting the companies to undertake Aadhaar-based e-KYC.

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India: Regulator mulls decision on settling claims in instalments – Asia Insurance Review

Policyholders may get to opt to receive payment of claims in instalments for personal accident and health insurance, once the recommendations of a committee are accepted by the IRDAI.

Various general/ health insurance companies lobbied the IRDAI on the subject. The insurance regulator set up a working group to study the proposal, reported Press Trust of India.

A report which has been submitted says that general and health insurers may be allowed to offer the option of payment of claims in installments or in a lump sum upon the occurrence of a contingent event in the case of indemnity products that have a fixed component. For example specific illness-based products, like cancer, have both fixed benefit and indemnity components.

The provision of receiving claims in installments or a lump sum is a decision that should be made by the policyholder and not the insurance company, the report says. Explicit consent should be given by the insured to the insurer.

The report also recommends that the claim payment period be capped by up to five years as per the needs of the target customers. Outstanding claim payout amounts shall be invested in line with IRDAI investment regulations, it adds.

The concept may be new to the general/ health insurance sector, but it has been adopted in the life insurance industry, especially for endowment policies.

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Source

LIFE INSURANCE

Postal dept to spin off life insurance biz - Financial Chronicle – 31st January 2019

The postal department plans to spin off the postal life insurance and rural postal life insurance operations into a separate business unit (SBU) for which a Cabinet note has been circulated, communications minister Manoj Sinha said on Wednesday.

"For postal life insurance and rural postal life insurance we have moved a Cabinet note. In the first phase it will involve creation of an SBU and in second phase a full fledged insurance company," Sinha told reporters on the sidelines of an event to mark the second anniversary celebration of India Post Payments Bank (IPPB).

The minister said he expects Cabinet approval for the move in a fortnight or so.

Sinha said IPPB has rolled out 1.26 lakh access points over the last five months and in the next week or 10 days the number is expected to rise to 1.36 lakh.

Nearly 800 access points are being opened by IPPB everyday and the payments bank has over 30 lakh customers availing banking services.

Twenty-one lakh transactions have been performed valued at over Rs 800 crore.

Over 1 lakh post office savings bank customers are availing inter-operable banking service by From linking their post office savings account to IPPB account. Further the IPPB mobile banking application has witnessed over 8 lakh downloads.

The postal department currently offers one of the oldest life insurance schemes —Postal Life Insurance (PLI), introduced in 1884. Since March 1995, Rural Postal Life Insurance (RPLI) has been providing insurance cover to people residing in rural areas, especially weaker sections and women living in rural areas.

Speaking on the occasion, finance minister Piyush Goyal said the IPPB would help enhance customer literacy about finance and the financial world by leveraging on the connect between the postman and a customer.

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Term policies: Why women need to buy life insurance – Financial Express – 30th January 2019

Data from Insurance Regulatory and Development Authority of India (Irdai) show that 90 lakh women bought life insurance policy in 2017-18. During the same period, 1.91 crore policies were purchased by men. So, women accounted for about one-third of the total business that year.

This is a substantial improvement in the representation of women in life insurance during the previous decade, when private insurers had strengthened their foothold. During 2017-18, the insurance agents and other intermediaries have been successful in selling insurance to only 139 women out of a population group of 10,000 women. This indicates that either a large number of women were not approached by them or a large number of women have declined to consider life insurance as a beneficial financial instrument.

There is an urgent need to educate women about the benefits of buying a life insurance policy which has several features that can serve them in many ways. Unfortunately, insurers have rarely initiated women-focused activities to create awareness about the benefits of life insurance.

Instrument of financial security

Life insurance is looked upon as an instrument of financial security for family members in case the bread earner unfortunately dies. Hence, the earning male member of the family is expected to buy life insurance. It is observed that only the third or fourth policy in the family is on the life of the wife or the girl child. Women, however, generally outlive men and they require a large fund for their own long-term care. Hence they require systematic financial planning on their part and they must actively consider buying life insurance. An endowment policy maturing at the age of 60 or beyond is one of the best saving tools for women.

Pay premium on time

A life insurance policy does not require regular monitoring except that one has to pay the premium on or before the due date or well within the grace period. It is free from complications of evaluating investment performance of funds and switching of funds from one category to another category. The conditions of the policy are such that discontinuation is discouraged and the policy keeps earning for itself by way of bonus accruals. If the maturity is planned at higher age beyond 60 years, then she can look forward to a

large lump sum amount which she can collect without any hassles from the insurer on maturity of the policy and invest the same for buying annuity policy for herself. A part of the total amount she can use for immediate requirements, if any. Some companies charge lower premium from women because they have better longevity than men.

No social security cover

Some women buy insurance when they feel their life is at higher risk due to occupational hazard or health hazard unique to females or even due to several archaic social rituals or practices. Another motivation for buying life insurance by women is the fact that in our country there is no social security system to support an orphan child or a child who has lost her mother or both parents. If housewives buy insurance, the premium goes out of the income of the husband, who is eligible for income tax relief under Section 80C. An earning woman is also eligible for tax relief. Premium paid by any individual or by his/her spouse is exempt from income tax up to `1.5 lakh under Section 80C. The entire proceeds of the life insurance under maturity as well as death claims is tax free. Hence, this is one investment plan which has least tax implications and the policyholder is not required to take services of CAs and other consultants.

In fact, every husband must buy an endowment policy for his wife with maturity date coinciding with her sixtieth birthday. Term policy is preferred by women in developed countries but in India, endowment type policy is more suitable for women. If the husband doesn't buy a policy for his wife, he must take care to buy a policy on his own life with adequate sum assured under Married Women Property Act (MWP). Policies purchased under MWP ensure that the proceeds are utilised for no other purpose than the welfare of the wife and children. This policy cannot be attached by any authority for any reason.

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Source

Buying a term plan? Buy from the green list – Mint – 29th January 2019

We have always advised our readers to buy a term plan for their life insurance needs. A term plan is the cheapest form of life insurance as it only charges the cost of insurance and keeps out any investment benefits. While the basic filter of cost is important to see while sifting through the plans available in the market, it's not sufficient. It is equally important to filter out insurers on the basis of their record of settling death claims.

Of course, life is a little easier now that regulations prohibit insurers from denying claims that come after three years of buying a policy, but a high repudiation rate, even when it's on account of claims that occur in the first three years, is a cause for worry. Claims settlement record, among other things, reflects the underwriting practices of an insurer.

HOW HAS YOUR INSURER FARED?

If you are interested in buying pure life insurance, you should also look at the claims settlement record of insurance companies by the amount of claims settled. A healthy record in claims settlement by the benefit amount bodes well. A huge difference in claims settlement by policy number and benefit amount indicates that policies with a small sum assured get settled but policies with a big sum assured are prone to rigorous scrutiny. Policies are sorted in desecending order on the basis of claims settlement by benefit amount

Top 5 companies in death claims settlement going by the number of policies | Bottom 5 companies in death claims settlement going by the number of policies | All figures in %

Insurer	Percentage of death claims paid: Number of policies	By benefit	Difference in claims paid by number and benefit amount
Edelweiss Tokio Life Insurance	95.24	97.78	-2.54
Bharti AXA Life Insurance	96.85	96.29	0.60
Max Life Insurance	98.26	95.26	3.00
Aegon Life Insurance	95.67	94.56	1.11
Life Insurance Corporation of India	98.04	94.45	3.59
Tata AIA Life Insurance	98.00	94.00	4.00
Aviva Life Insurance	94.45	92.25	2.20
SBI Life Insurance	96.76	92.13	4.63
Canara HSBC Oriental Bank of Commerce Life Insurance	95.22	92.03	3.19
ICICI Prudential Life Insurance	97.88	92.03	5.85
Aditya Birla Sun Life Insurance	96.38	90.51	5.87
Exide Life Insurance	96.81	89.61	7.20
IDBI Federal Life Insurance	91.99	89.39	2.60
Kotal Mahindra Old Mutual Life Insurance	93.72	88.88	4.84
DHFL Pramerica Life Insurance	96.62	88.68	7.94
HDFC Life Insurance	97.80	88.63	9.17
Reliance Life Insurance	95.17	86.11	9.06
Future Generali India Life Insurance	93.11	84.76	8.35
Bajaj Allianz Life Insurance	92.04	83.94	8.10
Star Union Dai-ichi Life Insurance	92.26	83.03	9.23
PNB Met Life India Insurance	91.12	82.40	8.72
Sahara India Life Insurance	82.74	81.67	1.07
IndiaFirst Life Insurance	89.83	79.78	10.05
Shriram Life Insurance	80.23	68.60	11.63

The table is for FY18 | Source: Irda annual report

The Insurance Regulatory and Development Authority of India (Irdai) gives out death claims settlement figures for retail policies from all the 24 life insurance companies in its annual report; the FY18 report was released earlier this month.

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Of course, life is a little easier now that regulations prohibit insurers from denying claims that come after three years of buying a policy, but a high repudiation rate, even when it's on account of claims that occur in the first three years, is a cause for worry. Claims settlement record, among other things, reflects the underwriting practices of an insurer. The Insurance Regulatory and Development Authority of India (Irdai) gives out death claims settlement figures for retail policies from all the 24 life insurance companies in its annual report; the FY18 report was released earlier this month.

How to look at it

The annual report documents the total number of death claims for retail policies that each insurer gets—by the number of policies and the benefit amount or the sum assured during the year. These then go in four buckets: claims settled, claims rejected, claims unclaimed and claims pending at the end of the year. For most insurers, the bucket of unclaimed claims is nil to tiny.

Looking at claims settled both by the number of policies and benefit amount is important, said Kapil Mehta, co-founder, www.securenow.in. "Looking at the percentage of claims settled by the number indicates how routinely the insurer settles death claims. A higher percentage of claims settled indicates a strong system for claim settlement, so policyholders who are going for bundled plans with small life insurance cover can be satisfied with a good settlement record by policy number," said Mehta.

But what if you are in the market to buy a high-value term plan? Imagine A, B and C buy life insurance. A and B buy a cover or sum assured of Rs 10 lakh each whereas C buys a cover of Rs 20 lakh. All of them die. Families of A and B get the claim but that of C is denied the claim. Going by the number of policies, the insurer settled 67% of the claims but if you go by the benefit amount, the settlement rate drops to 50%. That is why looking at claims settlement only by the number of policies is not enough.

The percentage of claims settled by the benefit amount is crucial. "A high settlement rate going by the benefit amount indicates the insurer is willing to settle even high-value claims. This stems from good underwriting practices at the time of policy sale that eliminates instances of fraud or misrepresentation that show up as early claims," added Mehta.

Looking at the percentage of claims settled by the benefit amount becomes all the more crucial when you are buying a term plan. "In case of pure protection plans looking at the sum assured is important because a higher death claim settlement rate using this metric indicates that the insurer doesn't discriminate between small- and big-value claims. This will happen if the sales practices are good and the policies are underwritten well at the time of sale," said K.S. Gopalakrishnan, chief executive officer, RGA Reinsurance Company's India business.

The report card

As per the regulator's annual report for FY18, on an average, the death claims settlement record for the industry has improved. For instance, going by the number of policies, the average settlement record in FY17 was 91.60%, which increased to 94.01% in FY18.

According to Gopalakrishnan, insurance companies should be settling at least 97% of the death claims, and in FY18 nine insurance companies made the cut compared to six in FY17. However, when you look at the number through the lens of benefit amount, the picture is not that rosy. In FY17, the industry, on an average, settled only 84% of the death claims and it improved to 88% in FY18. In fact, in FY17 none of the

companies reached a claim settlement rate of 97% and in FY18, only Edelweiss Tokio Life Insurance settled 98% of death claims by the benefit amount.

The claims settlement rate looks much healthier going by policy count compared to the benefit amount and this is primarily on account of high-value claims getting rejected. “Rejection usually only happens after due medical evidence. In case of death claims, rejection mostly happens in early claims for the industry. After three years the claims settlement for most insurers is nearly 100%. The biggest reason for early claim rejection is concealment of pre-existing conditions.

These concealments happen for larger amount benefits leading to a somewhat higher rejection rate in the larger ticket size cases," explained Ashish Vohra, executive director and chief executive officer, Reliance Nippon Life Insurance Co. Ltd. Reliance Life settled 95% of the claims by policy number but only 86% of the claims by benefit amount.

According to R.M. Vishakha, chief executive officer, IndiaFirst Life Insurance Co. Ltd, a big delta in the case of IndiaLife is due to the high-value pending cases due to unclear title of the nominees. IndiaFirst settled about 90% of the claims by policy number, whereas by benefit the settlement was only 80%.

In fact, IndiaFirst Life is also among the bottom five insurers going by claims settlement both by benefit amount and policy count. “One could argue that the on-boarding process could be strengthened but then, we are making the process difficult for 90% of the genuine customers to weed out the 10% of fraudulent customers.

We are a nine-year-old company and our focus has been on retail business for the last three years. This presents us with a situation of having a high percentage of early claims that impacts the claim settlement percentage. This will improve as we build up our retail portfolio," added Vishakha.

Claims reporting is another area that needs attention as per an executive of a private insurance company who didn’t want to be named. “The industry should adopt a standardised approach on reporting claims. Currently some companies don’t book claims that appear fraudulent or where documentation is incomplete. As a result, the settlement rate looks better. The life insurance council is, however, working on standardising this," he said.

What should you do?

While rejections may pertain primarily to early claims, it’s still a cause of worry given the gaining popularity of term plans. The practice for smooth on-boarding can be counterproductive if underwriting is done at the time of claims. Tracking claims settlement record of an insurer is important. In fact, in our regular term plan table, not only do we give you the cheapest term plans but we also showcase the claims settlement rate by benefit amount. Track this number, but don’t palm off the entire responsibility to your insurer.

You also need to make sure you disclose all the relevant information at the time of buying a policy because life insurance after all is a contract based on good faith. Dishonesty can land you in trouble, especially if it’s an early claim.

TOP

Source

Online Ulips are cost-efficient and tax-friendly: Still, should you invest in them? – Financial Express – 29th January 2019

Investors are increasingly becoming conscious of the costs involved in investment products. After all, costs eat into the returns and the damage is more pronounced in the long term. One of the market-linked tax-saving investments that many taxpayers are seriously considering is the unit-linked insurance plan (Ulip), precisely for its low cost in online version. Most life insurance companies offer online Ulips and to invest in them, one needs to go directly to the respective company’s website. SBI Life, HDFC Life, Aegon Life, Bajaj Allianz, ICICI Prudential and Aviva life Insurance are some of those who offer online Ulips.

What are the charges in an online Ulip?
Unlike in the past when the costs were neither capped and the online Ulips were not around, presently, the costs in Ulips are not only capped but the online Ulips carry far less costs than their older versions.

"The 4th generation new age Ulips which are designed for the long-term customer who buys the product online have a lower cost. Barring, FMC of 1 percent to 1.35 percent plus the mortality charges, there are no charges," says Vineet Arora, MD & CEO of Aegon Life Insurance company. Most online Ulips do not carry any Premium Allocation Charge and even the Policy Administration charge is considerably low. Remember, the mortality charges will, however, exist, till the fund value is below the sum assured in Ulip. Thereafter even mortality charges are not applied in Ulips where the death benefit is higher of fund value and sum assured.

Why online Ulips are low on costs
One main reason for low cost in online Ulips is that there is no intermediary like an insurance agent or a corporate agent in between and this cuts down the cost considerably. "Investing in a Ulip where any sort of distributors are associated may not be the best form of investments from customer perspective, due to high expenses, huge commissions and structures and policies which may not address to the investor's interest," says Arora.

Are Ulips most tax-friendly?
Other than the costs, investing in Ulips also comes with its tax advantages. "Ulips provide long-term capital gains tax (LTCG) advantage on investments as against direct equities and equity mutual funds. Also, Ulip investors can redeem the entire amount at the end of five years, though it is advisable to stay invested longer, even if the premium has been paid in instalments. While in ELSS or Tax saving FDs, only units or deposits that have completed the lock-in can be redeemed," informs Arora.

Online Ulip's buying process
Before one initiates the online buying process, it's better to understand the entire process of buying Ulips online — from filling the personal, medical and income details to disclosing of the material information, to uploading of documents to making the payment and finally receiving the policy document. Importantly, understand from the insurer by calling them up, when will you receive the proof for deduction under Section 80C for the premium paid towards Ulip. "Most of the companies including ours have a seamless on-boarding process. Documents can be scanned and attached during purchase or sent later. Medical test, if any, are easily coordinated by home visits at the convenience of the customer," informs Arora.

What to do?
Online Ulips provide tax and cost advantage over other competitive investments. Before choosing, consider the fund performance of the insurer and then decide. For better results, link it to one of your long-term goals and continue the Ulip till its maturity. Being an online investor, making an informed buying decision helps in not being mis-sold something you don't want to buy.

TOP

Source

Budget 2019: Life insurers want more tax benefits on single, limited-premium and pension plans – Financial Express – 28th January 2019

Life insurance is primarily meant for transferring the life risk to a insurance company, which is financially healthier than the life assured to compensate the nominee in case of untimely death of the insured person. Apart from the risk of early death, life insurance companies generally cover the risk of living too long – beyond a person's financial capacity to sustain – by providing pension plans as well.

Along with the pure risk cover through term insurance, insurance companies also offer investment options through endowment insurance plans, where not only death benefits, but the insured person gets maturity benefits also on surviving the term of the insurance plan.

Although such insurance plans offer lower return than other pure investment plans, but many people buy endowment plans to save taxes. However, before taking an insurance plan for availing tax benefits, you should ensure that the sum assured of the insurance plan is 10 times or more than the annual premium. Because, as per Section 10(10d) of the Income Tax Act, the premium and maturity amount would be tax free only if the sum assured is at least 10 times the annual premium. This makes single-premium plans as well as may limited-premium plans ineligible for getting tax benefits.

Now, insurance companies want the provisions under Section 10(10d) to get relaxed, so that even limited-premium as well as single-premium plans get some tax benefits.

"Current provision under section 10 (10d) is that the maturity proceeds from life insurance shall be liable to tax if the sum assured under the contract is lower than 10 times the premium. The provision does not differentiate between a regular premium paying policy, a limited premium paying policy and a single premium paying policy. It will be more appropriate to align this with the IRDA Product regulations, which define the minimum sum assured at a lower multiple of premium," said Sunil Sharma, Chief Actuary & Chief Risk Officer, Kotak Life Insurance.

Advocating for making pension plans more tax efficient, Sharma also said, "Retirement benefit in India is a very critical benefit for elderly people. It is important that government incentivise investments in long term savings in pension by having an explicit investment in pension products. This could be on Exempt-Exempt-Tax (EET) mechanism. This is likely to ensure retiring people in the future do not have to depend upon the resources from exchequer post-retirement."

TOP

Source

If you are a millennial, you need to have insurance cover: Vighnesh Shahane – Mint – 26th January 2019

If you have been wondering whether you should take a health insurance and life insurance, Vighnesh Shahane, managing director and chief executive officer, IDBI Federal Life Insurance, helps you decide. Shahane says if you are millennial you need to have insurance cover and your health can determine the cost of your insurance policy.

Edited excerpts: unfit you are, you will have to spend more in premium. Health insurance can also be denied if you are not fit. Your health can determine the cost of life insurance policies as well. In case of life insurance, go for a term plan as it is cheaper.

Right now online term plan is picking pace. What is your projection and do you think that people will be able to buy online without the help of an advisor?

When it comes to online term plans, the basic structure is almost the same with few changes in the features. You can buy term plans online, as it gives you the convenience of checking out the product online. Term plans are not complex and doesn't need handholding. But for any other kind of insurance

plans, you would be better off buying it after consulting an advisor purely because of the way it is structured. In case of Unit-linked insurance plans (Ulips), I am not convinced if the awareness level of the sellers is good enough to explain the product. The customers should be made aware of the product in details.

After the change in the taxation and the change in expense ratio, is Ulip worth considering?
I agree that Ulips are competitive after the regulator changed the charge structure and making it a customer centric product. However, Ulips should not be bought just for taxation. Insurance should be bought from protection point of you. Online Ulip is a good product, however, you should seek professional advice before buying it online.

What is your view on the sandbox model which allows companies you test new products with limited set of customers?
I think it is a step in the right direction where you can incubate new products. We have not yet progressed in that direction from our company. It is a question of time and this year we definitely will be exploring something in the sandbox model and it could start with term plan.

TOP

Source

GENERAL INSURANCE

Insurers a worried lot with no takers for title insurance, inherent defects policy - The Hindu Business Line – 31st January 2019

Title insurance and inherent defects policy, which were touted to provide much-needed relief to homebuyers, have no takers.

These products address the requirements of the Real Estate Regulation and Development Act 2016 (RERA), but have failed to break ground among the developer community.

Title insurance provides indemnity to property developers and homeowners against defects in land title that arise out of third-party challenges.

The inherent defects policy provides cover to new buildings for damages caused due to structural defects.

Insurers disappointed
Apart from HDFC ERGO, which sold two policies in July, not many companies have been able to push their offerings, sources told *BusinessLine*.

Insurance companies, which were anticipating easy take-off for these products, are a disappointed lot. "There was a lot of buzz as the need for title insurance was felt as part of RERA Act. We went out of our way and developed the product, created capacity and expertise, but the take-off rate has belied expectations," said Sanjay Datta, Chief – Underwriting and Claims, ICICI Lombard General Insurance.

According to Tajinder Mukherjee, Chairman and Managing Director, National Insurance Company (NIC), "not even a single buyer" has come forth to purchase it since the launch five to six months ago.

Bajaj Allianz General Insurance, too, is pushing for the sale of the product, and has quoted it to developers. But conversions are yet to happen, says Sasikumar Adidamu, its Chief Technical Officer.

Insurance broking company Marsh India has been getting a number of enquiries across stakeholders such as housing finance companies, lenders, private equity real estate players, and retail buyers.

"Some of the (enquiries) are at an advanced stage and conversions will happen over the next few months," said Sanjay Kedia, Country Head and CEO, Marsh India Insurance Brokers.

Builders unhappy, too

Builders, on their part, blame 'poor structuring' and 'high pricing' for the lukewarm response for title insurance.

"The policies are insuring the land and its title. But against this, the premium so levied is charged on every apartment sold. This is not right. It makes the policy unviable and expensive," a CREDAI member said, requesting anonymity.

The other point that developers raise are the high number of exceptions that may actually lead to claims being rejected. For instance, issues such as definition of "due diligence" – research that the developer does at the time of buying land – is not clearly defined. Again, developers are worried about subjective points such as "new information" leading to claim denials.

"Title insurance policies have too many exceptions," said Rishi Jain, MD of Jain Group. Moreover, builders get their insurance done in different ways. In most cases, they get their title insurance done by the land owner.

ppppp

"In many cases of joint development, it is the land owner who does title insurance, while suppliers and contractors get construction material quality and labourers insured," said Mayank Saksena, Managing Director, Anarock. Saksena maintains insurance companies should give more time for sales to pick up. But insurers say that lack of proper mechanism is the actual deterrent.

Since taking title insurance is still not mandatory, insurers feel making it enforceable will help push sales. According to Anurag Rastogi, Member of Executive Management, HDFC ERGO, uptake for title insurance policies will improve once Section 16 of the RERA Act is enforced and made mandatory.

"The Inherent Defect Insurance Policy is not mandatory under RERA. But a few States have done it. But further clarity is required," he said. Kedia of Marsh India, too, feels that "the Indian insurance market is ready" and "enough capacity has already been arranged". "But uptake will happen when taking such policies are made mandatory."

TOP

Source

Odisha hikes farmers' welfare scheme KALIA target beneficiaries five-fold – The Indian Express – 30th January 2019

The Odisha government Tuesday decided on a five-fold increase in the number of target beneficiaries for farmers' welfare scheme KALIA for the landless agricultural household category to 5 lakh during 2019-20.

Advertising

A proposal to this effect was approved at the Cabinet meeting chaired by Chief Minister Naveen Patnaik here. "Though earlier it was decided to restrict the number of beneficiaries under landless agricultural households to one lakh, now it has been decided to enhance it to 5 lakh during 2019-20," said Chief Secretary A P Padhi.

Each beneficiary household under the landless agricultural category will get Rs 12,500 as assistance under the Krushak Assistance for Livelihood and Income Augmentation (KALIA) scheme. Padhi said each beneficiary will be paid Rs 5,000 in the first tranche. The balance will be paid in two more tranches later.

He added that it has been decided to include all eligible beneficiaries to get assistance under the KALIA scheme. He said the landless agricultural households will be provided with small goat rearing unit/ fishery kit/ bee keeping and mushroom cultivation units based on the choice of the household.

KALIA scheme has five components such as support to cultivators for cultivation, livelihood support for landless agricultural labourers, life insurance support for cultivators and landless agricultural labourers, financial assistance to vulnerable agricultural households and interest free crop loan.

Meanwhile, the state government has transferred the first tranche of Rs 5,000 to 13 lakh small and marginal farmers and share croppers as support to cultivators, Padhi said.

In order to provide certainty to the farmers on the time of receipt of funds, it was decided that the Kharif assistance will be paid on 'Akshaya Tritiya' day and the Rabi assistance on agrarian festival 'Nuakhai' every year to the small and marginal farmers under the KALIA scheme, Padhi said.

"This will give them ample time to use this assistance for purchase of inputs and for making the required investments in the field operations based on their needs," Padhi said.

TOP

Source

Companies buying more and more insurance for directors & officers amid rising bankruptcy, fraud cases - The Economic Times – 28th January 2019

Companies are buying increased insurance to cover liabilities of directors and officers – known as D&O – after the recent growth in the number of such claims in bankruptcy and financial fraud cases.

While action taken by the Central Bureau of Investigation per se does not trigger D&O cover, it is invoked when the matter goes to court. Such insurance policies pay legal claims arising due to breach of duty. They indemnify the corporation, its directors and officers against wrongful actions that cause financial harm to a third party and result in a lawsuit.

"With increased number of cases, companies are opting for increased coverage for legal expenses — to get adequate cover to defend," said an insurance company executive. "We have seen companies double coverage in the aftermath of recent cases."

It's been a season of crackdowns by CBI on senior bankers. Last week, the agency named ICICI Bank's former chief executive Chanda Kochhar as an "accused" in the Videocon loan case. Last year, Usha Ananthasubramanian, former chief executive of Punjab National Bank, was charged by CBI in connection with an alleged Rs 14,000-crore fraud through fake letters of undertaking. RP Marathe, former managing director of Bank of Maharashtra, was arrested by the Pune police last year.

"Coverage is a function of who wants to defend what, but increased number of instances have forced companies to buy higher cover," said an insurance broker.

Company directors liable for their own and fellow-directors' decisions can face financial loss through litigation from shareholders, creditors, competitors, suppliers or regulatory bodies. Under such circumstances, the D&O policy provides security to the directors.

There are two parts of the D&O policy covering breach of duty, neglect, misstatements or errors – one for the entity and its employees and the other for directors.

The policy does not pay for claims when a person is personally culpable. In case of Satyam Computer Services, the insurance policy did not pay the defence cost of B Ramalinga Raju and financial chief Vadlamani Srinivas because it was outright fraud.

Last month, nine former directors of Infrastructure Leasing and Financial Services (IL&FS) were named in a petition by the government as decision makers, "controlling will and mind" for most other group companies and responsible for the crisis that followed a loan default.

Under the new Companies Act, all listed companies are required to have a D&O policy. After the Satyam case, companies made a dash to cover their directors. Also, independent directors have started asking for appropriate cover to join as board members.

TOP

Source

Can vintage cars be insured under motor insurance? – Mint – 28th January 2019

Having an insurance cover for your car is important. A part of the insurance, the third party liability cover, is mandatory by law, whereas the other part, the own-damage cover, is optional. Having a motor insurance could be helpful in covering the costs in case of some damage in an accident or even theft of your vehicle.

But what should you do if you own a vintage or classic car that needs special care? The quick answer is: keep it insured.

Before going into details about how they can be insured, remember that vintage and classic are two different categories of cars. According to the India Motor Tariff, any car manufactured prior to 31 December 1940 and certified by the Vintage and Classic Car Club of India can be considered a vintage car for the purpose of insurance. Similarly, any car manufactured after 31 December 1940 but before 31 December 1970 is considered as a classic car.

The cover

Is the insurance for these cars different than that for regular cars? Yes and no. As third-party liability cover is required for all registered vehicles, vintage car owners also need to take it. Just like regular cars, the premium based on engine displacement capacity, as set by the insurance regulator, is also applicable to these cars.

The difference is in own-damage insurance. For a regular car, own-damage cover is based on the insured declared value (IDV), which is calculated as the manufacturer's listing price of the vehicle minus depreciation. This IDV is the maximum sum assured that you can get in case of complete damage to the vehicle or theft. According to the India Motor Tariff, the 5% depreciation is accounted for arriving at the IDV of vehicles that are up to six months old. This goes up to 15% for vehicles that are less than one year old. The depreciation increases up to 50% over five years. Beyond five years, the value is mutually decided between the insurer and the vehicle owner.

However, the method to arrive at a sum assured for vintage cars is different. Here, the insurance company would look at additional documentation and certification. The foremost condition for vintage cars is that these should be registered with the Vintage and Classic Car Club of India. Insurance companies Mint spoke to said in most cases, the insurance company appoints a surveyor to get a valuation report. Insurers also accept the valuation done by the Vintage and Classic Car Club of India.
Apart from valuation, the report also focuses on factors like the cost of spares and repairs for that particular model, as spares and service for these is not readily available. The premium for older models are higher as often spares for these need to be imported and are even made to order in some cases. Once the owner of the vehicle and the insurance company agree upon a value, own-damage cover is given for the value.

A senior official of a general insurance company said these policies are not listed on their website as the value is different in each case. Moreover, the official said, in most cases owners of these vehicles sign up for an own-damage cover only for shorter durations for rallies and exhibitions, which has pro-rated premium for the shorter duration. This is done under the 'Endorsement 31' of the India Motor Tariff that allows additional coverage for a specific event like an exhibition or a rally. This is done because the own-damage cover for these cars turns out to be costly as the spares and service is expensive.

Largely, the insurance and related benefits for vintage cars are similar to that of any regular car. Just that the process is a little more layered for vintage cars.

TOP

Source

Budget may provide Rs 4000-cr capital infusion for PSU general insurers - The Hindu Business Line – 27th January 2019

The upcoming Budget may have provision for Rs 4,000-crore capital infusion for public sector general insurance companies to shore up their capital.

The Budget 2019-20 is likely to be presented on February 1.

According to sources, the Department of Financial Services sought Rs 4,000 crore in the Budget for fund infusion in three insurance companies -- National Insurance Company, Oriental Insurance Company and United India Insurance Company.

Depending on the capital that Budget provides, individual allocation would be made, sources added. This capital is required to strengthen their financial health.

The profitability of many general insurance companies, including that of state-owned ones has been under pressure owing to rising underwriting losses and higher claims.

It is to be noted that the government, in Budget 2018-19, had proposed to merge National Insurance Company, Oriental Insurance Company and United India Insurance Company.Finance Minister Arun Jaitley in the Budget speech had announced that the three companies would be merged into a single insurance entity. The process of merger is likely to be completed during the current fiscal.

As on March 31, 2017, the three companies together had more than 200 insurance products with a total premium of Rs 41,461 crore and a market share of around 35 per cent.

Their combined net worth is Rs 9,243 crore, with total employee strength of around 44,000 spread over 6,000 offices.

In 2017, state-owned New India Assurance Company and General Insurance Corporation of India were listed on bourses.

Initial estimates suggest that the combined entity formed by merging the three insurers will be the largest non-life insurance company in India, valued at Rs 1.2-1.5 lakh crore.

TOP

Source

HEALTH INSURANCE

Maharashtra insurance scheme saves Rs 200 crore – The times of India – 1st February 2019

The state government's free health insurance scheme for economically backward citizens has managed to save a whopping Rs 112 crore in annual premium to be paid to a nationalized insurance company this year.

The Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) allows families-or over 20 lakh beneficiaries-with an annual income of less than Rs 1 lakh per annum to avail free surgeries of up to Rs 1.5 lakh in any of 492 empanelled hospitals across the state.

The state government insured every eligible family for Rs 690 last year, but after months of negotiations with the insurance company, it has paid only Rs 640 per family this year. "We got the new agreement on Thursday," said Dr Sudhakar Shinde who heads the MJPJAY.

A few months back, the yojana had managed to get Rs 80 crore back from the insurer (National Insurance Company) for failing to carry out IEC activities as promised. The Rs 200 crore saved through premium payment and settlement could be used to develop public health infrastructure, said Dr Shinde.

TOP

Source

Ayushman Bharat rollout fraught with delays in some States - The Hindu Business Line – 31st January 2019

After initial enthusiasm, the Pradhan Mantri Jan Arogya Yojana (PM-JAY), popularly referred to as Ayushman Bharat, seems to be fraught with delays and uncertainty in few States.

Though West Bengal has decided to opt out, it may not be easy as the Centre has paid up to Rs 175 crore to the State for the scheme. Chief Minister Mamta Banerjee had declared that the State wants to withdraw from the scheme.

“West Bengal has made declarations of withdrawal from the scheme, but what about the funds of close to Rs 175 crore that have been contributed by the Central government to the State,” a senior official in National Health Agency, which implements the PM-JAY, told BusinessLine.

CEO of Ayushman Bharat, Indu Bhushan, has written to West Bengal’s Additional Secretary Rajiva Sinha on January 11 reminding that the Centre had already contributed it’s share. After Bhushan’s reply to Sinha’s letter a day earlier stating that West Bengal wants to pull out, there has been no further communication from the State.

Political situation

“It is a political situation,” the official pointed out. “If they pull out, they will have to talk about repaying the Centre's share. Are they willing to do that? Or provide utilisation certificates for the amount they have already used? They have totally cut off communication after the Centre wrote to them on January 11,” the official added.

Banerjee had threatened to disassociate with the scheme over branding issues — she had expected a co-branding with the existing Swasthya Saathi scheme of the State. In Kerala too, aggressive branding of the scheme as run by the Centre has been deemed problematic. However, Kerala is in the process of floating bids to finalise the insurance agencies.

While Meghalaya and Puducherry had signed the MoU way back in June, Kerala and Punjab had signed the MoU in end-October. Rajasthan, which had signed the MoU in October, is yet to start the roll-out.

Despite hurdles, NHA officials are hopeful to get some States on board by February or April. "Meghalaya is starting the scheme by February 1, while Puducherry and Punjab will hopefully start by February 15. Kerala, we are hoping will start by April 1. We are not sure when Rajasthan though," said the official.

CEO of Ayushman Bharat, Indu Bhushan said, "All States will positively come around and some of these are still in the process of finalising insurance agencies."

TOP

Source

Kerala budget: Hunger-free Kerala health schemes - The Economic Times – 31st January 2019

Kerala finance minister Thomas Issac on Thursday announced Rs 20 crore for hunger-free Kerala project in the state budget.Major announcements were made in the health sector including comprehensive health insurance schemes.

"The comprehensive insurance scheme would be implemented this year," said Issac in the budget speech. This would be implemented in four parts, he said in the speech adding that all families would be protected by insurance through the scheme.

"Insurance premium for as many as 40 lakh people would be paid by the government itself. The rest can join the scheme by paying the premium," it was announced in the budget. "Medical expense of as much as Rs1 lakh would be provided directly by the insurance companies. Upto Rs5 lakh would be provided for lifestyle diseases," Issac said in the budget.

Issac also announced that oncologists would be appointed in all medical colleges in the state. As many as 4217 new vacancies have been created in the health sector, he said. The new announcement came in the Kerala budget. This is Isaac's 10th budget and Pinarayi Vijayan government's third budget.

Welfare schemes

Major welfare schemes were announced in the Kerala Budget-2019 on Thursday. Welfare pension would be increased from Rs1100 to Rs1200. It would be made Rs5000 in 5 years. As much as Rs20 crore was allotted for the welfare of Endosulfan tragedy victims. As many as 20,000 self-help groups (SHGs) for the elderly would be set up in the state, Issac said. A grant of Rs5000 would be given to these SHGs, announcement was made in the budget.

Welfare pension for the elderly would be increased by Rs100, the budget announced. Special schools of the government received an allotment of Rs35 crore with the money being set aside for various projects for these schools. The budget also announced projects for the care of the differently abled.

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TOP

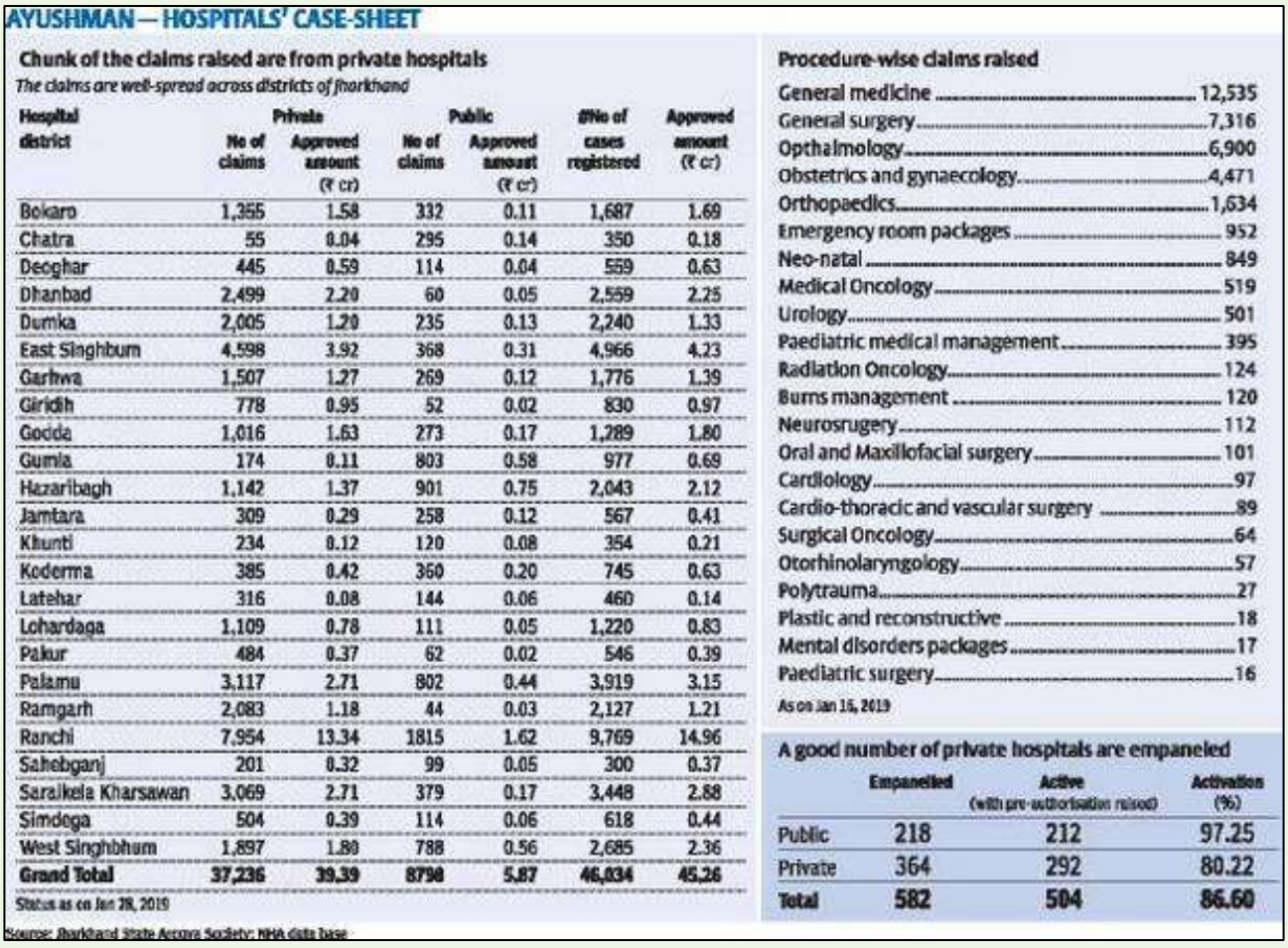
Source

Ayushman Bharat: For Jharkhand, roping in an insurance partner has worked well - The Hindu Business Line – 30th January 2019

As the car screeches to a halt in the naxal-affected Khunti district of Jharkhand, the unpretentious building in the middle of nowhere hits you. Not only because it houses a 65-bed eye hospital, but also because (a staff casually mentions it as I get fidgety) beyond this point lie the naxal-hit forests of the Khunti district.

Situated about 55 km from the State's capital city of Ranchi, the SGVS Hospital on the national highway has done close to 160 eye surgeries under the Ayushman Bharat scheme since October last year.

"I travelled nearly 60-70 km from the Lapung district to get my eye surgery done here. One of the people close to our village who had done operation for his child told me about the scheme, and that's how I'm here," says Manuwel Beck.



AYUSHMAN — HOSPITALS' CASE-SHEET

Chunk of the claims raised are from private hospitals

The claims are well-spread across districts of Jharkhand

Hospital district	Private		Public		#No of cases registered	Approved amount (₹ cr)
	No of claims	Approved amount (₹ cr)	No of claims	Approved amount (₹ cr)		
Bokaro	1,355	1.58	332	0.11	1,687	1.69
Chatra	55	0.04	295	0.14	350	0.18
Deoghar	445	0.59	114	0.04	559	0.63
Dhanbad	2,499	2.20	60	0.05	2,559	2.25
Dumka	2,005	1.20	235	0.13	2,240	1.33
East Singhbum	4,598	3.92	368	0.31	4,966	4.23
Garhwa	1,507	1.27	269	0.12	1,776	1.39
Giridih	778	0.95	52	0.02	830	0.97
Godda	1,016	1.63	273	0.17	1,289	1.80
Gumla	174	0.11	803	0.58	977	0.69
Hazaribagh	1,142	1.37	901	0.75	2,043	2.12
Jamtara	309	0.29	258	0.12	567	0.41
Khunti	234	0.12	120	0.08	354	0.21
Koderma	385	0.42	360	0.20	745	0.63
Latehar	316	0.08	144	0.06	460	0.14
Lohardaga	1,109	0.78	111	0.05	1,220	0.83
Pakur	484	0.37	62	0.02	546	0.39
Palamu	3,117	2.71	802	0.44	3,919	3.15
Ramgarh	2,083	1.18	44	0.03	2,127	1.21
Ranchi	7,954	13.34	1815	1.62	9,769	14.96
Sahebganj	201	0.32	99	0.05	300	0.37
Saraikela Kharsawan	3,069	2.71	379	0.17	3,448	2.88
Simdega	504	0.39	114	0.06	618	0.44
West Singhbhum	1,897	1.80	788	0.56	2,685	2.36
Grand Total	**37,236**	**39.39**	**8798**	**5.87**	**46,034**	**45.26**

Status as on Jan 28, 2019

Source: Jharkhand State Aarogya Society; NHA data base

Procedure-wise claims raised

General medicine	12,535
General surgery	7,316
Opthalmology	6,900
Obstetrics and gynaecology	4,471
Orthopaedics	1,634
Emergency room packages	952
Neo-natal	849
Medical Oncology	519
Urology	501
Paediatric medical management	395
Radiation Oncology	124
Burns management	120
Neurosrugery	112
Oral and Maxillofacial surgery	101
Cardiology	97
Cardio-thoracic and vascular surgery	89
Surgical Oncology	64
Otorhinolaryngology	57
Polytrauma	27
Plastic and reconstructive	18
Mental disorders packages	17
Paediatric surgery	16

As on Jan 15, 2019

A good number of private hospitals are empaneled

	Empaneled	Active (with pre-authorisation raised)	Activation (%)
Public	218	212	97.25
Private	364	292	80.22
Total	582	504	86.60

Many others, fluttering outside the hospital warming their hands and sipping hot tea — having travelled over 200-300 km for treatment — seem quite aware of the benefits under the Centre's Ayushman Bharat, which offers a cover of Rs 5 lakh per family.

At the Ranchi Institute of Neuro-Psychiatry & Allied Sciences, where mental illness is treated — bipolar and Schizophrenia are the most common disorders — Ayushman has made a big difference.

Abhishek Shrivastava, the additional ED of the Jharkhand State Arogya Society, which implements Ayushman in the State, explains that the scheme has helped the poor acknowledge the importance of treating mental illness and brought in more awareness.

Jharkhand, a greenfield State, has been an exception where the progress under Ayushman has been heartening so far. Of the 580-odd hospitals empanelled so far, over 60 per cent are private entities. Also, about 86 per cent of the empanelled hospitals are active (where at least one pre-authorisation claim has been raised). Over 46,000-odd claims have been raised so far, of which 80 per cent are from private hospitals. This is in sharp contrast to the meagre 5,700-odd claims raised in Bihar so far.

While both are greenfield States, Bihar has adopted the trust model, whereas Jharkhand has been one of the nine states that have adopted the hybrid model to implement Ayushman. This has made a huge difference in the way the scheme operates and delivers in both States.

Trust vs insurance model

There are basically three models by which the Ayushman Bharat scheme can be implemented. Under an insurance model, the premiums are paid to the insurance company, which administers and pays the claim.

Under a trust-based model, each State forms its own trust to manage the scheme and claims will be disbursed from a corpus created from central and State government contributions.

Under the hybrid model, a part of the claim comes under the insurance model while the balance gets processed under trust.

For States that have adopted a hybrid model, empanelling bigger hospitals has been easier, as the risk is ring-fenced with the additional presence of an insurance player.

"In a hybrid model, frauds are minimised because the insurance player is incentivised to keep the claims low. If the claims' rejection is legitimate, then we support it. But if the claims are rejected on flimsy reasons, we try to control it. In the longer run, the revenue outflow will depend on the fraud detection built into the system. If the insurance player raises issues on fraud then we will look into it and de-empanel hospitals wherever need be. This balance is not there in a trust model," explains Divyanshu Jha, the Executive Director of Jharkhand State Arogya Society.

Instrumental in ramping up the scheme in the State, Divyanshu explains that States have been given the flexibility to adopt the model that best suits them to implement Ayushman, which is a key positive.

"The hybrid model helps limit the State's revenue outflow for the scheme, while satisfying the need for direct State intervention. There is an insurance coverage of upto Rs 1 lakh, while Rs 4 lakh is under trust model. The idea was that the bulk of the claims will come within the initial Rs 1 lakh. Since the State did not have the capacity, we wanted to start with insurance, learn the ropes and then ramp up," he adds.

Vast resources

The project office of the Pradhan Mantri Jan Arogya Yojana (PMJAY)-Ayushman Bharat that I visited houses three third-party administrators (TPAs) —MDIndia, Medi Assist and Safeway.

The vast team of TPAs (roped in by the insurance player) helps ensure minimal pendency of claims and bring in a robust process in place. In particular, emergency requests from hospitals are approved the same day, with zero pendency.

Data suggests that over 70 per cent of claims raised have been paid so far in the State. Compare this with the poor resources in Bihar, and the lacunae in adopting a pure trust model becomes evident. The TPA in Bihar is MedSave which quoted a price of just Rs 1.83 per household, to take care of pre-authorisation of claims, claim approval, MIS, etc. The quality is poor, and the manpower is not adequate to handle the flow of claims under the Ayushman Bharat scheme, explain the officials in the State.

TOP

Source

As PMJAY gains more beneficiaries, government may hike funding for scheme – Mint – 30th January 2019

The litmus test for Prime Minister Narendra Modi's ambitious healthcare scheme Ayushman Bharat-Pradhan Mantri Jan Arogya Yojna (AB-PMJAY) has begun with an ever increasing number of beneficiaries seeking medical treatment under the programme, prompting the need for increased financing in the budget.

The scheme which is completing five months, has attracted much attention from across India. Modi reiterated that AB-PMJAY highlighted his government's emphasis on the health sector and was a big step to ensure universal health coverage for the masses.

The Union health ministry claimed that so far more than 900,000 patients have availed treatment worth Rs 1,338 crore under the scheme. The next step for providing quality and universal health coverage is also being debted.

AB-PMJAY, dubbed 'Modicare' and labelled as the world's largest health insurance scheme, aims to provide health cover for secondary and tertiary hospitalisation to nearly 40% of the population, or more than 100 million poor and vulnerable households, based on the socio-economic caste census (SECC) database. The premium is paid by the government and the scheme offers a health cover of Rs 5 lakh per family per year.

A research paper published in the latest issue of *Indian Journal of Public Health,* which used the National Sample Survey Office (NSSO) data released in 2015, revealed that ailing people account for 8.9% and 11.8% of the rural and urban population, respectively, while a majority did not have any health cover.

"Although infrastructure in urban India fares better than that found in rural areas, it is still largely dependent on the level of living of the family. The percentage distribution of sources of finance for hospitalised treatment captures only a part of the picture and does not fully describe the complexity of issues," said Shri Mukesh, joint director, National Sample Survey Office (Coordination and Publication Division), Ministry of Statistics and Programme Implementation, who is also the author of the research paper.

"It is also important to measure other socioeconomic aspects and issues related to governance and policy, which capture the multi-dimensional nature of health financing in India," he added.

Considering the very low penetration of health insurance in India, out-of-pocket spending for healthcare services is very high. For effective population management, experts said that universal health insurance will act as a powerful catalyst. They also said that to create a robust healthcare ecosystem and take AB-PMJAY to the next level, the government should make health insurance mandatory for all in a phased manner.

"The major reason for the low penetration of health insurance is because it is currently optional. While the government has taken laudable steps to introduce a health insurance scheme for the weaker section with AB-PMJAY, the government could also explore making health insurance coverage mandatory for all citizens," said Siddhartha Bhattacharya, secretary general, NATHEALTH, a healthcare service provider.

"Starting with organized sector, employees could be given the option to either pay their employees' state insurance (ESI) contribution or purchasing insurance from any Insurance Regulatory and Development Authority (IRDA)-regulated insurer. Scaling up PMJAY to all citizens, including middle and upper middle class, needs to be done in the next phase."

As India drives towards making healthcare more accessible, affordable and inclusive, quality will be key, given that low-quality healthcare, if scaled, can set the clock back.

"Quality improvement in India will require a dedicated authority to develop policy framework to support quality measurement and improvement strategies," said Krishna Reddy, country director, ACCESS Health International, an advisory and implementation partner.

TOP

Source

Is Ayushman Bharat facing a funds squeeze? - The Hindu Business Line – 29th January 2019

The Pradhan Mantri Jan Arogya Yojana (PM-JAY) popularly known as 'Ayushman Bharat,' is receiving a lesser slice of the pie than it it has demanded from the Centre.

The scheme's budget has been slashed by at least Rs 800 crore, official sources told *BusinessLine.* While the National Health Agency (NHA) — the implementation agency of PM-JAY — had demanded Rs 7,400 crore to meet the expenditure for 2019-20, the Ministry of Finance initially agreed to allocate close to Rs 7,200 crore. But, around 10 days ago, the Ministry of Health and Family Welfare (MoHFW) wrote to the Ministry of Finance asking it to further cut down PM-JAY's budget as it was eating into the funds meant for other schemes.

"The Finance Ministry accepted MoHFW's plea and further reduced PM-JAY's budget to nearly Rs 6,400 crore," a senior health official said. While the NHA implements PM-JAY, the National Health Mission (NHM) implements a majority of health schemes like immunisation, setting up health and wellness centres, managing communicable and non-communicable diseases and so on. Separately, the NHM had demanded Rs 35,000 crore in 2019-20, of which the Finance Ministry has sanctioned Rs 26,945 crore.

"Current year's sanctions are close to 23 per cent less than what we demanded, yet it is a seven per cent hike from what NHM was allocated last year, which was Rs 25,155 crore," a senior NHM official stated. After the funds were slashed, the sentiment in the NHA office was subdued. An official said: "Given the way we are ramping up beneficiaries, and also as more States join in, we expect to spend up to Rs 12,000 crore in 2019-20, 60 per cent of which — Rs 7,200 crore — is the Centre's share. We need these funds."

Struggle for funds

The scheme has been struggling for funds in the current financial year (2018-19) too. Ayushman Bharat was announced in last year's Union Budget and the Cabinet had allocated Rs 3,135 crore for 2018-19 (funds that will be sufficient till March this year), but officials confirmed that this allocation has been reduced to Rs 2,400 crore. "Of this reduced amount, Rs 1,000 crore for up to March 2019 is yet to be received by us," said the official.

Slow inflow of funds is delaying the Centre's payments to States. Up to 28 States and Union Territories are on board currently, and at least 14 States have sent multiple emails to the NHA requesting release of funds due to them. "Till date, the Centre has released close to Rs 766 crore to States, but has not been able to pay the current additional liability of over Rs 1,700 crore," the official stated.

Strain on States

Tamil Nadu had written to the Centre requesting reimbursement of close to Rs 360 crore, which it paid as premium, on behalf of the Centre, to United India Insurance, earlier in January. "Till date, we have received only a tenth of the total funds demanded from the Centre. They have paid us Rs 25 crore for premium amount and Rs 11 crore for covering administrative costs, a total of Rs 36 crore. We are operating the scheme on State funds," said P Uma Maheshwari, TN Health Systems' project director.

In another instance, Madhya Pradesh had demanded over hundred crore but has been given Rs 15 crore till date. NHA officials fear that non-disbursement of central funds in a timely manner can have a domino effect if States cease to co-operate. "It may have a staggering effect on last-mile delivery to the patient, if States, and then hospitals that provide services, are not paid on time. This was the biggest grouse in the Rashtriya Swasthya Bima Yojana too, the scheme that preceded PM-JAY," said the NHA official.

The MoHFW has been kept on a tight leash by the Ministry of Finance despite demanding more budget. Last year, the MoHFW had demanded over Rs 70,000 crore to meet its expenditure, but was allocated Rs 52, 800 crore (a decrease of 24.57 per cent). "This year, we have demanded up to Rs 80,000 crore," a senior official said.

TOP

Source

J&K govt approves health insurance scheme for employees and pensioners – The Indian Express – 29th January 2019

The Jammu and Kashmir government Monday approved a health insurance scheme for its employees and pensioners based on "trust model". The approval came at a meeting of the State Administrative Council (SAC) chaired by Governor Satya Pal Malik. Under this model, a trust will be set up by the state government which would design appropriate insurance product and offer it to designated beneficiaries, an official spokesperson said.

On October 27 last year, the Governor had ordered foreclosure of the contract with Reliance General Insurance for implementing the group mediclaim health insurance for state employees and asked the Anti-Corruption Bureau (ACB) to probe the matter after it sparked a row.

After the scrapping of the previous medical claim policy, the state government constituted a committee of officers headed by principal secretary, Health and Medical Education, to examine the possibility of operating the health insurance scheme through third party administrator (TPA) by dispensing with the insurer and intermediary.

The committee, which was mandated to determine the outline of such a scheme and a selection procedure after discussing and analysing health insurance models of other states, submitted its report along with three models, the spokesperson said.

"The SAC considered the options or models suggested by the 'committee of officers' vis-a-vis advantages-disadvantages of each model. After considering the feasibility of various models and their merits, the SAC approved the trust model," he said. The spokesperson said the administration of the scheme, including the collection of premia, enrollment of the insured, settlement of claims, will be with the said trust.

"This measure would address the issue on a long-term basis and do away with the issues of renewal and other issues which crop up every now and then," the spokesperson said, adding that this would also ensure close monitoring.

TOP

Source

Railway hospitals to implement Ayushman Bharat scheme - The Economic Times – 25th January 2019

Railway hospitals across the country will soon provide treatment to eligible families under the Centre's ambitious Ayushman Bharat scheme, an official statement said Thursday. In addition, eligible families will soon be able to get benefits under the scheme at hospitals under the New Delhi Municipal Council and the North Delhi Municipal Corporation, a statement by the National Health Authority, the apex body implementing the insurance programme, said.

The NHA Thursday signed an MoU with the Ministry of Railways in this regard.

The Union government on September 23 had launched the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, which aims to provide a cover of Rs 5 lakh per family per year and is likely to benefit more than 10 crore poor families across the country.

As per the MoU, identified medical establishments having inpatient hospitalisations under the Ministry's Railway Health Services department across its 16 zones will be empanelled with the PMJAY to implement the scheme. It will provide secondary and tertiary care to eligible individuals.

"The government is committed to developing a strategic partnership with providers to strengthen service delivery under the scheme so that the vision of AB PM-JAY becomes a reality. Empanelment of health care providers and institutions is a key aspect of this partnership," Dr Indu Bhushan, the NHA CEO, said.

Speaking about the collaboration, he said, "I am confident that our partnership with the Railways, the NDMC and the North Delhi Municipal Corporation will go a long way in ensuring access to quality healthcare to the poor in the country through Ayushman Bharat PM-JAY scheme".

This will also help strengthen and expand the existing infrastructure and quality of services of these public hospitals, he said.

"We are happy to partner with the NHA to implement Ayushman Bharat. This collaboration will help the beneficiaries get access to quality healthcare even in the remotest parts of the country through our network of railway hospitals," Dr Gajendra Kumar, the principal executive director of Health in the Ministry of Railways, said.

TOP

Source

CROP INSURANCE

'Private insurance firms will hurt farmers' – The Times of India – 29th January 2018

All India Kisan Congress vice-president Kodanda Reddy on Monday said private insurance companies will have no interest in rescuing farmers but Prime Minister's Fasal Bhima Yojana that aims at providing crop insurance to farmers has included private insurance companies in the scheme.

Addressing the media, Kodanda Reddy expressed apprehensions that inclusion of private companies by the PM would actually hurt farmers as private companies by the PM would actually hurt farmers as private companies will have no interest in rescuing farmers.

Traditionally, state-run insurance companies have been providing the farm insurance. The southern states' kisan congress conference beginning at Gandhi Bhavan on Tuesday will discuss this issue and also

minimum support price, Acts pertaining to seeds, crop insurance, farmers suicides, disaster relief, and how to make agriculture profitable, among others. Kisan Congress will send its suggestions to the AICC for inclusion in the party's election manifesto for the ensuing Lok Sabha polls.

TOP

Source

Big relief for farmers! Govt may approve agri-package on Monday; Waiver of crop loan interest or complete waiver of insurance premium on card – Financial Express – 27th January 2019

The cabinet on Monday is likely to approve a package for farmers to boost their income and address distress in the farm sector, sources said, adding that the move will come ahead of the general elections. "The cabinet meeting is scheduled tomorrow (Monday) and the agriculture ministry's proposal on addressing income deficit syndrome of small and marginal farmers is on the agenda," a highly placed source said.

The agriculture ministry has recommended several options to provide both short and long term solutions to address agrarian distress.

However, a final call will be taken in the cabinet meeting as a huge cost is involved, the sources said. One of the options proposed is waiving interest on crop loans for farmers who pay on time, costing an additional Rs15,000 crore to the exchequer, the sources stated. There is also a proposal to completely waive premium for taking insurance policy for food crops. The centre is also evaluating the scheme followed by the Telangana and Odisha governments wherein a fixed amount is transferred directly into the bank account of farmers, the sources added.

Agriculture Minister Radha Mohan Singh had recently indicated that the government would announce an agriculture package before the 2019-20 Budget, to be presented on February 1. Experts said the government has less time to implement any new scheme.

The measure has to be such that it can be implemented faster to reap the political gains during the election. It may be noted that the central government has taken farmers' issues seriously after the ruling BJP was defeated in Madhya Pradesh, Rajasthan and Chhattisgarh in the recent state polls, where rural distress was a key factor. Farmers are in distress owing to fall in prices of most crops in view of bumper crop.

TOP

Source

REINSURANCE

Easier norms for foreign players to up competition in reinsurance market - Business Standard – 30th January 2019

The sector has seen the entry of nine foreign players as well as a domestic private sector company The Insurance Regulatory and Development Authority of India (Irdai) recently relaxed the norms for foreign reinsurers that have set up shop in India, a step likely to trigger intense competition in the country's reinsurance space.

While Irdai retained the right of first refusal for the state-owned General Insurance Corporation of India (GIC Re), insurance companies will now have to simultaneously seek terms from at least four foreign

reinsurance branches. If the Indian reinsurers cannot match the rates quoted by their foreign counterparts, then they stand to lose business.

This, experts believe, will drive up competition in the market which is currently dominated by GIC Re, and will thus provide the Indian insurance companies with more options to choose from.

According to Kapil Mehta, CEO of Secure Now, an insurance broking firm, "A lot of reinsurers are coming in as the market is growing at a rapid pace. Also, there is much more clarity on the mechanism through which they can enter the market. In fact, many more reinsurers are expected to come into the market in the next year or so."

The order of preference does make it difficult for new entrants to build their business. But the market is so huge that new players will come anyway, he added.

Rating agency Moody's believes that the new rules will give local insurers access to a broader range of reinsurers. They will nudge domestic insurers to actively use reinsurance for risk management and reduce balance sheet volatility.

So, will global reinsurers make life difficult for their domestic counterparts? Experts say that while competition will certainly grow, keeping GIC Re on its toes to enhance capacity and services, it is unlikely that there will be any significant erosion in its market share any time soon.

Says Alice Vaidyan, Chairman of GIC Re, "When faced with free competition, GIC Re has gone from strength to strength and has now emerged as the 10th largest global reinsurer. We do not think the new rules will have any material impact on the market or GIC Re's competitive position."

Industry experts feel that the idea behind retaining the right of first refusal is to encourage more domestic companies to set up their reinsurance business in India. This will also help retain the business within the country instead of letting it go to insurance hubs like Singapore and London.

"The aim of the insurance regulator is to have maximum business reinsured within the Indian territory with domestic capacity and only the rest being passed on to foreign reinsurers," Irdai said in its annual report for the year 2017-18.

Says T S Vijayan, former IRDAI Chairman, "Reinsurance is a specialised business and follows global practices. Until now a large part of India's business was going abroad. After the entry of new players, the business will be retained in India."

As for what the competition will do to pricing and product variety, there is no consensus on whether the new rules will impact the pricing of premiums. But they would certainly lead to the development of new products, particularly for non-life insurers, say experts.

Vijayan points out, "The competition will improve only if these new reinsurers bring India-specific products. It's too early to say if the premiums will come down as the risks taken over by companies will be different."

Secure Now's Mehta adds that the impact will be greater on product innovation as the reinsurers who come in could have interesting products that are absent here. At present 11 reinsurers operate out of India. Of these, nine are foreign reinsurers who have branches here and the other two are Indian reinsurers, namely, GIC Re and ITI Re.

GIC Re remains the most dominant player in the market. However, its share in the total Indian reinsurance market premiums has come down from 99.8 per cent in FY 17 to 83 per cent in FY18, thus reflecting the growing presence of foreign reinsurers.

The net premium underwritten by GIC Re grew from Rs 30,175 crore in FY17 to Rs 37,634 crore in FY18 — an uptick of 25 per cent. The total premium on reinsurance accepted by foreign reinsurance branches in FY18 was Rs 6,216 crore, out of which Swiss Re had the largest share of Rs 2,047 crore, while Munich Re and SCOR SE reported Rs 1,307 crore and Rs 1,186 crore respectively.

According to Irdai, out of the nine foreign reinsurance branches in India, in FY18, three have reported net profit while the rest have reported losses.

With new players establishing branches in India and the rules for effective competition in place, the regulator has now set its sight on making India a reinsurance hub. The low insurance penetration levels and high vulnerability to natural catastrophes provide the Indian insurance industry ample scope to expand in an aggressive way, Irdai said in its annual report of 2017-18.

The regulator also points to the development of Gujarat International Financial Tec-City (GIFT City) in Ahmedabad as a step in the right direction. Many insurance and reinsurance firms have shown their interest in setting up shop there, indicating India's potential to compete with global financial centres like Singapore, London and Tokyo.

However, experts feel that the regulator should first create a level-playing field for reinsurers in the country and then look at making India a reinsurance hub. "We would like to be on a level-playing field with the other reinsurers," says C B Murali, CEO of Allianz SE in India.

TOP

Source

INSURANCE CASES

NCDRC directs doctor to pay Rs 3 lakh to patient for negligent treatment and wrong billing - The Times of India – 29th January 2019

The National Consumer Disputes Redressal Commission (NCDRC) has directed a doctor to pay a compensation of Rs 3 lakh to a patient for being negligent in treating him, wrongly billing him for the treatment and causing him "mental agony" and "pain". A bench of the apex consumer commission comprising President R K Agrawal and member M Shreesha asked the doctor, Geeta Jindal, to pay the compensation for the medical expenses incurred by the patient and the inflated billing.

The New India Insurance Company Limited would be liable to pay the amount as the doctor was covered by an indemnity policy, the bench noted.

The tribunal said the doctor was not only "negligent" in treating the patient but had also wrongly billed the victim for the "treatment that was never rendered" and therefore, it amounted to an unfair trade practice.

The tribunal allowed the revision petition of Haryana resident Dinesh Joshi, seeking a review of the state consumer disputes redressal commission's order dated May 10, 2016 dismissing his complaint, in which he had sought a direction to the doctor to refund the amount charged from him on account of wrong and unnecessary treatment.

According to the petition, Joshi had visited Jindal in Panchkula, Haryana on October 4, 2011 as he had a severe pain in his buttock. Jindal had given him medicines stating that he was suffering from fissures and that the pain would decrease within two days.

However, after two days, Joshi, who was still in severe pain, was rushed to Jindal and was admitted to a hospital, where she charged him Rs 36,450 for the treatment, despite assuring him earlier that the total expenses for his treatment would not exceed Rs 7,000, the petition said.

The doctor had charged Joshi Rs 12,500 towards ICU charges, though the latter was never put in one, and the patient was also billed for surgical instruments that were never used on him, it claimed.

The tribunal noted that the normal practice in private nursing homes and hospitals was that the management would provide for all the medicines and surgical items likely to be used and the billing would be done subsequently, confined to the items used.

"In the present case, as the surgery was not performed, the medicines/surgical items which were not used were billed. There is also no evidence on record that the patient was ever put in an ICU.

"In fact, it is the main case of the treating doctor that surgery was not required to be performed and the question of putting the patient in an ICU did not arise. Therefore, the ICU charges of Rs 12,500 were wrongly billed. We are of the considered view that such a billing amounts to unfair trade practice," the tribunal said.

"Having regards to the bills, the averments made in the written version, the information procured under RTI and the treatment rendered, we are of the considered view that the treating doctor is not only negligent in the treatment of the patient but has also wrongly billed the complainant with charges for which the treatment was never rendered and therefore, we are of the opinion that this act also amounts to unfair trade practice," it added.

The district and the state consumer forum had ruled out any medical negligence on the doctor's part but had jointly held the scanning centre that had diagnosed Joshi and the insurance company liable for paying him compensation.

TOP

Source

HC to the rescue of Umapur farmers denied insurance – The Times of India – 29th January 2019

The Aurangabad bench of Bombay High Court has come to the rescue of hundreds of farmers from Umapur circle of Beed district denied compensation under the Centre's ambitious Pradhan Mantri Fasal Bima Yojna for crops that failed during Kharif 2016.

The division bench of the HC comprising Justice SS Shinde and Justice RG Avachat directed the State Bank of India's branch at Umapur to compensate the farmers after the bank committed a typographical error while transferring insurance Company, which was chosen as insurer for the farmers from the circle.

The SBI, while transferring the premium amount of Rs 49.22 lakh, mistakenly mentioned it to be of farmers from Beed circle, instead of Umapur circle. Farmers reached out to the insurance company seeking compensation for failed crops but were turned down by the insurance firm, citing the error by the bank.

The bank has been directed to pay the amount with seven per cent interest rate per annum. The decision came on a PIL filed by Amarsinha Pandit, NCP strongman and MLC from Beed district.

The central government introduced PMFBY, a crop insurance scheme, to provide financial support to farmers suffering crop loss and damages arising out of unforeseen events and calamities. The state issued a Government Resolution on July 5, 2016 for implementation of the scheme. Following the HC decision, the state will be providing crop insurance worth Rs 5 crore to the farmers," Pandit said.

As per the division of responsibilities, HDFC Ergo General Insurance Company was tasked as insurer for farmers of Umapur circle, while the local branch of the SBI was shortlisted by the state, with whom insurance premium was to be deposited by farmers. Under the scheme, farmers pay maximum 2 per cent premium for kharif crop, 1.5 per cent for rabi and % per cent for commercial and horticultural crops –the remaining premium is shared equally by Centre and state governments.

It was after the failure of Kharif 2016, the farmers reached out to the insurance company seeking the compensation amount, but it was turned down by the insurance company.

Representing the MLC, lawyer NB Khandare contested that the bank was supposed to submit a consolidated proposal to the insurance company well within time. But much to the shock of farmers, SBI Umapur Branch submitted the proposal with a mistake. With the situation in a dead end, the matter was referred to the Government of India, Ministry of Agriculture, Cooperation and Farmers Welfare, which too ruled that it is the SBI which is at fault.

Despite this, the bank failed to pay the amount, following which MLC Pandit took the initiative and filed a PIL before the HC, which too concluded the SBI was at fault.

The division bench ruled, 'The State Bank of India, Branch at Umapur, in Georai tehsil shall pay, within eight weeks, the claims of 1,562 farmers of Umapur revenue circle with interest thereon at the rate of seven per cent per annum from this date to the date of payment.

The HC further directed the insurance company shall repay, within eight weeks, the insurance premium amounting to Rs. 49,22,185 with interest thereon at the rate of 10 per cent per annum from the date it received the amount of premium to the date of payment to the State Bank of India.

TOP

Source

NCDRC directs insurance firm to pay over Rs 27 lakh to Delhi Vidyut Board – The Hindu – 28th January 2019

Dismissing an appeal moved by the New India Assurance insurance company, the National Consumer Disputes Redressal Commission (NCDRC) upheld a State commission order directing the insurance company to cover the claim put forth by the Delhi Power Company, for theft of over Rs 27 lakh.

"There is no dispute regarding the facts that the Delhi Vidyut Board was insured for theft or loss of cash during transit and that a theft of Rs 27 lakh took place during transit, when the cash van was parked, to unload the cash. The [insurance company] has however declined to honour its commitment on the ground that as per the investigation report, there was breach of contract," the Bench observed.

While upholding the State commission order, the apex consumer disputes Redressal forum said, "Having gone through the order of the state commission and other record placed before us, we see no violation or breach of conditions of the policy. There is no cause to interfere with the well-reasoned order passed by the state commission."

The insurance company had contended that the theft had occurred due to "gross negligence of the security guard leaving the cash van unattended."

TOP

Source

Thane: 6 claimed Rs 80 lakh insurance with fake death certificates – The Times of India – 28th January 2019

Six people, including two Mumbra doctors and a Thane civic-run crematorium employee, were arrested by the Kalyan crime branch unit of Thane police for allegedly preparing death certificates of people who were alive and claiming insurance.

The police said the mastermind, Kalyan resident Chandrakant Shinde (65), in connivance with Tejpal Mehrol, a sweeper at Thane Municipal Corporation's Mumbra crematorium, and Dr Abdul Siddiqui (38) and Dr Imran Siddiqui (41), who issued at least 10 bogus death certificates, claimed compensation of Rs 80 lakh from two private insurance firms.

They also managed to procure death certificates from the TMC of three people who live in Andhra Pradesh and sought Rs 50 lakh as payout, said the police. The others arrested were Chandrakant's son Narayan and daughter-in-law Laxmi, who were the beneficiaries.

The police said other beneficiaries were Chandrakant's relatives who were unaware about the insurance money claimed on their names as most of them are illiterate. Investigators are also probing the role of the insurance company officials and TMC employees.

The police said Chandrakant, who used to sell cutlery items in a local trains, started the scam in 2015 and roped in Mehrol. Explaining the modus operandi, the police said Mehrol would fill TMC forms required to get a death certificate. He would give Dr Abdul and Dr Imran Rs 2,000-Rs 10,000 to give a fake doctor's certificate showing the cause of death as 'natural'.

Using the fake doctor's death certificate, Mehrol would then get a death certificate from the civic health department and hand it over to Chandrakant, who would claim the money from the insurance company. Chandrakant had also claimed Rs 12.9 lakh by submitting a 'death certificate' of his daughter-in-law Laxmi. Narayan was the nominee in her policy, said the police.

The racket came to light when Thane resident Venkat Shinde, who is Chandrakant's nephew, checked his life insurance policy document and found his death certificate instead. He immediately called up the insurance firm and was shocked to learn that Rs 4.8 lakh payout had already been given.

He then approached the Kalyan crime branch unit. Senior inspector Sanju John formed a team under assistant police inspector Santosh Shevale, who questioned Chandrakant as he had bought the policy for Venkat. John said: "Chandrakant confessed to the crime and spilled the beans on Mehrol and the doctors."

Shevale said, "The gang has claimed nearly Rs 80 lakh insurance money using fake death certificates in at least 10 cases. We are probing the role of others, including the beneficiaries and staff from the insurance companies' claims department." Investigators also probing why TMC health department staffers issued death certificates to Mehrol.

TOP

Source

PENSION

Atal Pension Yojana: PFRDA sees subscriber base at 1.5 cr by March - The Hindu Business Line – 25th January 2019

Pension regulator PFRDA is eyeing a subscriber base of 1.5 crore for the Atal Pension Yojana (APY) by March-end, a top official said.

This will be a substantial jump over the subscriber base of 97 lakh as of March-end last year, Supratim Bandyopadhyay, Member (Finance), PFRDA, told *BusinessLine*.

"We have already added 44 lakh new APY subscribers up to December this fiscal. We will certainly cross 50 lakh this fiscal. The aspiration of 1.5 crore subscriber base is doable by March," he said.

He felt the aim for APY should be to cover 4 per cent of the target population (about 40 crore in the 18-40 age bracket), from the current level of 3.5 per cent.

Bandyopadhyay also said PFRDA was hopeful that the upcoming Budget would announce changes to the APY scheme so as to give a further boost to the programme.

Key suggestions

Of the three main suggestions given by PFRDA to the Finance Ministry on APY, one related to increasing the monthly pension limit to Rs 10,000 from the current slab of up to Rs 5,000.

At present, there are five slabs of pension from Rs 1,000-5,000 per month. There has been a lot of feedback from the market for higher pension amounts as many feel that Rs 5,000 at the age of 60, 20 to 30 years from now, will not be sufficient.

PFRDA has, on its part, done actuarial valuation, and the reports have been sent to the Finance Ministry to enable them take an appropriate decision for the upcoming Budget.

The other suggestions made by PFRDA were raising the maximum age bar to enter the scheme to up to 50 years from 40 years now, and also giving a nod for auto-enrolment for APY.

At present, the age to enter APY is between 18 and 40, but an increase in the same by another 10 years – 18-50 years – will help expand the subscriber base, he added. It may be recalled that APY became operational from June 1, 2015, and is available to all citizens in the age group of 18-40 years.

Under the scheme, a subscriber would receive a minimum guaranteed pension of Rs 1,000 to Rs 5000 per month, depending on his contribution, from the age of 60 years.

The same pension would be paid to the spouse of the subscriber and, on the demise of both, the accumulated pension wealth is returned to the nominee.

APY follows the same investment pattern as applicable to the NPS contribution of Central government employees. PFRDA added about 50 lakh new subscribers under the scheme in 2017-18.

TOP

Source

India: Regulator to audit pension funds – Asia Insurance Review

The pension regulator, the Pension Fund Regulatory and Development Authority (PFRDA), plans to audit pension funds which manage total pension assets worth over INR2.8 trn ($39.4bn) for 24.8m subscribers.

The aim is to ascertain whether corporate governance at pension funds is in a good state.The pension fund managers, appointed to manage the retirement savings of subscribers under the National Pension System (NPS), will be audited on seven parameters, including reporting and disclosures, investments, corporate governance and senior management, reported DNA.

The proposed exercise is intended to be conducted with the objective of bringing all operations and processes in compliance with laws, regulations, and guidelines, said PFRDA.The audit will also look closely at the senior management of the pension funds. The audit scope includes looking at whether the appointed senior management have adequate professional experience in the requisite field and whether the compliance officer immediately and independently reports any non-compliance observed by him or her to the PFRDA or the NPS Trust.

The audit will look too at the work of the investment committee and risk management committee. This would include checking whether the pension fund has drawn up an investment policy and placed it before the board of directors for its approval. Also, the board would be checked as to whether or not it reviews on a half-yearly basis the fund's investment policy and related implementation, etc. Areas of conflict of interest will be looked into.

The other parameters that the audit wouldcover include process, investments, reporting & disclosures. At present, there are eight pension fund managers with State Bank of India, LIC and UT being the biggest. The others are from HDFC, Kotak, Reliance, ICICI and Birla. The NPS was launched on 1 January 2004 initially for central government employees (excluding the armed forces) and was adopted by state governments and state autonomous bodies also subsequently. NPS was extended to all other citizens of India with effect from 1 May 2009.

TOP

Source

IRDAI CIRCULAR

IRDAI issued circular regarding Allowing Aadhaar Card as one of the acceptable documents for KYC - under certain conditions.

TOP

Source

GLOBAL NEWS

South Korea: Non-life insurers told to move out – Asia Insurance review

Korean non-life insurers should look for new markets to counter the deteriorating business environment at home, urged the chairman of the General Insurance Association of Korea, Kim Yong-duk. Mr Kim stressed that it is now impossible for insurers to enjoy sustainable growth if they do business in the old way, reported The Korea Times.

"Firms won't meet customer standards anymore if they persist in using conventional business methods," he said at a media conference last month. He also mentioned the motor insurance sector, which has sustained heavy losses due to growing maintenance and repair service fees.

"The nation's non-life insurers are likely to sustain losses of KRW700 bn ($629m) this year," he said.

"However, we can't just simply raise premiums to cover the losses. We also need to share the burden of the economic slowdown," he said. He added that other solutions for insurers include curbing insurance fraud and unnecessary expenditure.

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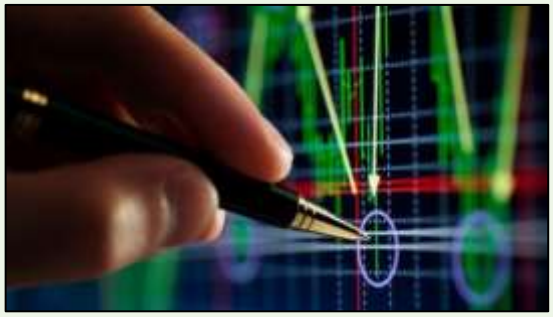
China: Regulator urges insurers to invest in quality stocks and bonds – Asia Insurance Review



The CBIRC is encouraging insurance companies to invest their long term funds in the stocks and bonds of high-quality listed companies, the regulatory agency's spokesman Mr Xiao Yuanqi has said. Insurers are urged too to broaden the scope of their investments in special products.

According to a statement by the CBIRC yesterday, Mr Xiao said that such investments will help ensure the stable and healthy development of listed companies and capital markets, and allow insurers to improve their investment portfolios.

Such moves will also support insurers in carrying out value investments and long-term investments as well as in studying and promoting a mechanism to assess insurers' asset and liability management. The moves aim too to attract more insurance funds to participate in the capital market.

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Australia: Insurance will be first to be cut by strapped households – Asia Insurance Review

Cutting back on insurance is the first thing Aussies plan to do to deal with ongoing financial uncertainty, according to a new study by comparethemarket.com.au.

More than three quarters of Australians plan to make changes to their household finances this year. Health insurance, car insurance and home and contents insurance will be axed first, reported news.com.au citing the report.

The survey of almost 1,100 people found that almost two-thirds would review their health insurance, half would check their car insurance and more than 40% would review energy plans and home and contents insurance.

It also found that 44% of people plan to cut back on personal spending such as clothes and eating out, 41% plan to reduce energy usage, 35% will buy less groceries and 19% will downgrade or cancel travel plans.

Comparethemarket.com.au's general manager of banking, Mr Rod Attrill, said households are more focused on their own financial situation amid uncertainty around interest rates and housing markets.

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