भारतीय बीमा संस्थान
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INSUNEWS

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QUOTE OF THE WEEK

"We all need people who will give us feedback. That's how we improve."

Bill Gates

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Both-to-Blame Clause

A both-to-blame clause is a clause in an ocean marine insurance contract that states that, due to their negligence, both parties involved must pay for losses when two ships collide at sea. This can include the owners as well as the shippers of the vessels involved in the accident.

Despite modern technology, shipping accidents still occur at sea. When they do, both ship captains can be at fault. For example, if each captain left the helm of the ship unattended and the ships crashed into each other, then both parties could be responsible for causing the accident. If both parties have ocean marine insurance policies with both-to-blame clauses, then each party will burden a portion of the losses from the accident.

INSURANCE INDUSTRY

How technology is transforming the insurance industry for rural India? – The Times of India - 7th July 2022

India is the second-most populous country in the world yet is still in its nascent stage in insuring its people. India's insurance penetration stands at 3.76% of the GDP against other Asian nations such as China, Malaysia, and Thailand which recorded 4.99, 4.72, and 4.30 percent respectively. This is because India has a 70% rural population, and most of them are unaware of utilizing insurance as a risk management tool. As a result, the rural market remains untapped by giant insurance companies.

Due to substantial differences in the geographic and economic landscape, penetration of insurance is low in rural India despite consistent efforts by insurance companies. Also, low insurance awareness, availability of 'one size fits all' products, tedious documentation, and low income makes the market difficult to capture. Traditional distribution channels suffer last-mile delivery challenges and hence are unable to offer insurance at a low premium.

Addressing awareness, accessibility, and affordability challenges

For more than a decade, low insurance penetration has affected the underprivileged population, whether residing in urban or rural areas. The awareness of insurance as financial security is relatively low in rural areas. Also, most of the policies are available at a premium that is unaffordable to them.

To increase insurance penetration in rural areas, the imperative is to overcome barriers related to awareness and affordability that widens the inaccessibility gap. Making products accessible to the rural population through traditional distribution channels is challenging for insurance providers. Thus, to improvise insurance penetration, a holistic approach is required that can address awareness, accessibility, and affordability challenges.

Technology as an enabler

Before tapping into the rural markets, it is significant to keep technology penetration ahead of insurance penetration. The technologies such as AI, ML, and data analytics, insurtech platforms can analyze the behavior and preferences of the rural populace and curate products accordingly. In addition, the adoption of digital models can also enhance the accessibility of insurance products for people at different income levels.

In recent five years, the rural market has witnessed a surge in smartphone usage. With internet connectivity, they no longer have to visit brick-and-mortar insurance offices for policy issuance. Thus, with the help of the insurtech platforms, they can get affordable policies digitally. Insurtech platforms have eased out the process of selling insurance and simplified the user experience for effective engagement. With seamless API integration and end-to-end digital process, providing customer details for insurance policies is easier which also makes the dissemination of instant policies faster.

Micro and bite-sized insurance products

Currently, life insurance coverage in rural India stands below 10% while less than even 20% of the rural populace has any form of health insurance. Introducing micro and bite-sized insurance products tailored to the rural population's needs can improve the insurance penetration rate in the country. Also, the focus must shift to providing effective policies at a low premium with minimum documents. This will smoothen the process of buying an insurance policy that is not heavy in their pockets and provides optimum coverage at an affordable price.

Apart from developing customized insurance products, another imperative is to make them accessible to the rural population. To enable this, the collaboration between pure-play financial institutions and insurtech platforms along with API integrations can make the accessibility of products seamless via their smartphones. The API Integrations have the potential to offer a greater degree of personalization to the customers with a quick turnaround time. Having said that, the deployment of the right PoSPs or local agents for physical assistance is still necessary to build trust among the rural population. The adoption of a hybrid model to combine physical and digital selling modes can boost financial literacy by increasing awareness, and adoption of insurance policies in rural areas.

Bottomline

For more than two decades, insurance penetration has been less than 4%. The rural insurance market is ripe for digital transformation and awaits the foray of insurtech companies to tap the untapped rural market. By combining technology with purpose, insurance players are enabling financial institutions to deliver affordable yet highly relevant insurance products to the rural segment with ease.

(The writer is Vikul Goyal.)

TOP

Government notifies host of procedural changes in GST rules – Business Standard – 7th July 2022

The government has notified a host of procedural changes in the GST rules, including levy of interest for wrongful utilisation of ITC and turnover threshold for filing annual returns for the 2021-22 fiscal.

The changes were vetted by the Goods and Services Tax (GST) Council at its meeting last week.

With the amendments notified by the Central Board of Indirect Taxes and Customs (CBIC), businesses have also been allowed to make tax payments on the GSTN portal by using IMPS and UPI payment modes.

Businesses with aggregate annual turnover of up to Rs 2 crore in the fiscal ended March 31, 2022, are exempt from filing annual returns for 2021-22, as per the amended rules.

The amendment also clarified that interest on incorrect availment of input tax credit (ITC) would only apply in cases where such credit is utilised. The Finance Act had brought in a provision related to levying of interest on ITC wrongly availed and utilised.

The provision would come into effect from July 5 and would apply retrospectively from July 1, 2017, -- the date of GST rollout.

Deloitte India Partner, Leader Indirect Tax, Mahesh Jaising said the notification issued for retrospective amendment to Section 50(3), clarifying that interest on incorrect availment of credit would only apply in cases where such credit is utilised, is a welcome one.

KPMG Tax Partner Abhishek Jain said the GST law has been suitably amended to say that interest shall be payable only in respect of the ITC availed and utilised. "This change is much appreciated, and puts a final close to this issue."

The amendments also provide for automatic revocation of GST registrations cancelled once the return filing is regularised.

"This will reduce the time and effort spent by taxpayers in getting registrations revoked even after regularisation of the return filings. It will reduce the interaction and improve the faceless compliances under GST, Jaising said.

Jain said these changes in rules would also help the small players in undertaking compliances, and will lighten the burden for taxpayers with less than Rs 2 crore turnover to the extent of filing of annual returns under GST.

AMRG & Associates Senior Partner Rajat Mohan said other important changes include extension of time-limit specified under Section 73 (determination of tax) under the GST Act for issuance of an order for FY 2017-18 to September 30, 2023.

However, no extensions have been provided for any other financial year.

"In relation to the delayed filing of refund applications during the COVID period (March 1, 2020 to February 28, 2022), suitable extension has been granted that will enable numerous exporters to encash the refunds stuck in litigation," Mohan said.

Jain said that considering the COVID scenario of the last two years for India, the government has extended the limitation period under GST for issuance of notice to taxpayers who have not paid/ short paid the tax due. Similarly, relaxation in limitation is granted for filing refunds.

"While the intention of the government is to curb revenue leakage, this change keeps the businesses exposed to departmental audits and assessments for some additional time. This being said, this change also ensures that genuine taxpayers are not denied their refund claims," Jain added.

According to Mohan, the manner of calculation of interest on delayed payment of tax has been notified and that would help taxpayers in making precise calculation of the tax dues.

As per the amended rules, every invoice issued by an MSME supplier will have a standard declaration printed on invoice regarding non-applicability of e-invoice.

Also, cash ledger balance can be transferred from one GST registered entity to another under the same PAN.

TOP

Don't bar PSU insurers on solvency: Govt – The Times of India – 6th July 2022

The finance ministry has asked government departments not to disqualify three public sector insurance companies from covering state-owned entities for failing to meet minimum capital norms. The three companies — National Insurance, Oriental Insurance and United India Insurance — currently do not meet the solvency margin norms prescribed by the Insurance Regulatory and Development Authority of India (Irdai). Solvency margin requirements are the insurance industry's equivalent to the capital adequacy ratio in the banking sector, which requires entities to meet net worth criteria before taking on risks. National Insurance has disclosed an available solvency margin ratio of 0.63 against the 1.5

minimum prescribed by the regulator. For Oriental Insurance, it is even lower at 0.15. United India Insurance has 0.83.

"Some central public sector undertakings include a minimum solvency ratio of 1.5 as one of the eligibility criteria for insurers' participation. This makes three of the four public sector companies ineligible (New India Assurance makes the cut)," the note from the department of financial services said. It added that insurance regulator IRDAI has allowed forbearance to these companies considering all aspects and allowed them to continue underwriting business. The note also said that the reinsured liability is not factored into the calculation of the solvency ratio.

"The intention behind the plea may be good but it can create a contrary result," said K K Srinivasan, former member or IRDAI. "Also, the statement that IRDAI has shown forbearance on solvency issues can be misleading. The statement that reinsurance is not considered by IRDAI while reckoning solvency is also apparently misleading," said Srinivasan.

According to a consultant heading the insurance practice, the market perceives implicit government support when a wholly owned state entity makes a promise. Any business done based on this implicit guarantee becomes a liability on the government. "A government guarantee is a form of quasi capital. From a governance standpoint, it is better to replace quasi capital with real capital," he said.

Executives in private companies agree that PSU support is required for large projects and government programmes — therefore, it is essential that the government capitalises them.

(The writer is Mayur Shetty.)

TOP

Why insurance can be a life saver for investors wealth in cryptocurrency assets – Live Mint – 2nd July 2022

When you opt for deposits or loans at a bank, generally, you do have the option of taking insurance against it. Insurance acts as a protection for your money invested or borrowed. This is what the cryptocurrency markets are lacking currently, a proper insurance mechanism to protect investors' wealth. So far this year, crypto markets have witnessed some deep depressions in their performance with major digital currency assets drastically correcting to low levels, some even clocked zero grounds baffling investors. This has led to many cryptocurrency exchanges halting their withdrawals and deposits.

On Friday, the global crypto market was recovering from its previous sessions' steep declines. The market cap of global cryptocurrencies jumped 1.21% over the last day and was around $870 billion. In June, the crypto market erased its $1 trillion mark. The crypto market's leader Bitcoin's dominance is around 42.44% below compared to 44.44% dominance two weeks ago.

Currently, Bitcoin trades at around $19,400.14 up 1.61% with a market cap of around $369.22 billion. While counterpart Ether soared 3.3% and was trading around $1,065.76 with a market cap of $129.05 billion. However, in seven trading sessions, Bitcoin recorded a loss of more than 8% and Ether dipped nearly 12%.

The top 10 cryptocurrencies have recorded a sharp downfall in their price level in a week. Binance's (BNB) weekly drop is over 8.3%, while Cardano's weekly decline is over 9.7%, XRP shed around 13.5%, and Solana dived about 18.5%, as per CoinMarketCap data. Tether, USD Coin, Binance USD, and DogeCoin saw a slight decline in the week too.

Last month, crypto exchanges like Binance, Celsius, and CoinFlex among others halted their withdrawals and deposits to cap the outflow in crypto markets. The reason behind cryptocurrency platforms halting their withdrawals and deposits is that there is a massive decline in their liquidity. It is almost like a common practice now, every time there is a sharp crash in cryptocurrencies, some exchanges vulnerable to the comedown halt their withdrawals. The latest Three Arrow Capital (3AC) collapse dampened confidence in crypto markets once again after the infamous Terra tokens flash crash which wiped out hundreds of millions of investors' money. On Monday, crypto platform, Voyager issued a notice of default to 3AC of a loan amounting to $650 million.

Earlier this week, a court in the British Virgin Islands ordered the liquidation of crypto hedge fund Three Arrows Capital (3AC), after the company suffered major losses in the recent market turmoil. Recently, 3AC liquidated its positions after it failed to meet margin calls. According to Arcane Research analysts Vetle Lunde, uncertainty related to the collapse of 3AC, corresponding defaults, and lending platform Celsius' halting of withdrawals as they face a potential bankruptcy is leading to a vicious withdrawal cycle on other centralized lending platforms.

Further, Lunde explained that the growing withdrawals suggest that users of crypto lending platforms are getting more cautious amid the growing uncertainty in the market, leading to a bank run and a vicious feedback loop for lending platforms, which already experience massive pressure pending the unresolved 3AC contagion. It is situations like these that make it vital for investors to have insurance against their crypto assets investment. However, in the crypto industry, insurance has not gained traction or is not widely adopted. Vinit Khandare, CEO and Founder, MyFundBazaar pointed out that from cyber attacks to rug pulls, the cryptocurrency-sphere remains a rather exposed industry and therefore, investors are increasingly looking at ways to protect their assets from being exploited - crypto insurance.

Khandare explains that although the companies that people use to buy and store crypto are in some ways similar to banks, these platforms don't have the deposit insurance that bank or investment accounts have. If the companies that operate these platforms were to fail, there's no guarantee that the investor would be able to recover the value of their crypto - this lack of protection reflects the fact that regulators are still catching up to the crypto industry. Insurance also serves as a reminder that while crypto platforms might seem secure — some are publicly traded companies — they're operating in an industry that has almost no rules and few safety nets, the MyFundBazaar founder added.

In Khandare's opinion, regulators are still learning the art of approaching crypto - being an entirely speculative investment, it is injudicious to put the deposit insurance and government backing behind those crypto assets, every investor needs to come to a realisation that what they're doing is not putting money in a bank, but a gamble. The mounting effort to regulate the crypto industry probably won't be over anytime soon - all the chaos in the crypto market has more people thinking about the fate of their money. That may not be good news for crypto investors, but it's certainly good news if they're in the burgeoning crypto-insurance business.

(The writer is Pooja Sitaram Jaiswar.)

TOP

INSURANCE REGULATION

IRDA agrees to look into Covid-19 insurance claims – Live Mint – 5th July 2022

The Insurance Regulatory and Development Authority (IRDA) on Monday agreed to look into the Covid-19 policy claims that were rejected by insurance companies. This comes after a public interest litigation was filed by a Manav Seva Dham (petitioner), a social services' trust against various insurance companies before the Bombay High Court. According to the petition, it has been alleged that various insurance providers engaged in a number of offences, misusing policyholder funds, rerouting funds through additional businesses, and paying exorbitant overriding commissions to banks and their agents.

“The insurance companies are unjustly denying their Covid-19-related claims, it claimed, even in the midst of the ongoing pandemic Covid-19, in which the country’s residents have not only lost their jobs but also depleted their money", it said. Additionally, the petitioner submitted that Insurance companies have caused wrongful losses to the policyholders. Essentially the petitioner asked the court to ass an order to ensure that the insurance claims submitted by the policyholders due to Covid-19 pandemic were not arbitrarily rejected.

The petition stated that due to the widespread pandemic the general insurance companies received a significant lot of claims from the policyholders. More than 80, 000 claims were received by the non-life insurance industry. However, despite having health insurance policies, the claims of the policyholders were blatantly rejected by these insurance companies citing frivolous reason.

Further, it was submitted by the social trust that during the second wave of the pandemic the insurance firms settled only 54% of the claims received from the customers who subscribed to an additional Covid health insurance as of March 2021.

The petitioner argued that only claims totaling to ₹7,900 crore have been settled by insurers out of the total claims of ₹14,680 crore under the Covid health insurance programmes. The rest of the claims were arbitrarily been rejected without citing any valid reason or specifying the reason for denial or rejection of claims by referring to the corresponding policy conditions, the petition stated. While on the other hand, only a handful of people got portion of the total treatment cost at hospitals as their claims from the insurance companies.

The social trust also claimed that it discovered that the policyholders were receiving just 45–80 % of the overall hospital expenses because they were embroiled in a fight between hospitals and insurance companies over the treatment of consumables. Despite having comprehensive insurance coverage. More important, in terms of the year on year growth of the insurance companies under the head of advertisements were outrageous, the petition stated. The marketing spend of these companies did not actually correspond with the respective spend and reach of these companies.

The petitioner asserts that the marketing and customer reach of the insurance companies in the private sector do not correspond with their marketing spend, and the petitioner is concerned that these sums are being syphoned off by the insurance companies under the guise of advertising. The petitioner compares the above numbers with a few of the rapidly expanding companies in India with significant revenue from operations and wider customer reach, such as Pidilite and Dabur India.

The petitioner submitted that pertinently, the general insurance industry underwrote premiums worth ₹1.69 Lakh Crore in FY19 as against Rs. 1.5o Lakh Crore in the same period last year, registering a growth rate of 12.47%. The trust submitted that even with the insurance premium increasing manifold, the profitability has surprisingly and inexplicably witnessed a substantial decline.
“It appears that many general insurance companies are siphoning off the funds of the policy holders under the garb of payment of insurance claims and in all possibility could have even created fictitious policy holders to route the money into their own pockets", it said.

The social trust due to these above reasons has asked the court to take cognizance and impose penalties on the insurance companies for non-compliance. After hearing both the parties the Bombay High court diposed of the PIL.

(The writer is Priyanka Gawande.)

TOP

Irdai asks insurers to adopt states to boost reach – The Times of India – 2nd July 2022

Insurance regulator Irdai has asked companies to take a leaf from the banking industry's strategy for inclusion by companies adopting individual states as lead insurers. Irdai has also set goals in terms of insurance penetration for the life and non-life industry. Irdai chairman Debashish Panda held the first of his proposed bi-monthly meeting with insurance chiefs — Bima Manthan — this week in Hyderabad. In the meeting, insurers were guided to increase the growth rate and were individually provided indicative targets along with unique states and UTs to lead on. In the meeting, the Insurance Information Bureau made a presentation on enhancing its role and also its corporatisation. The IIB was set up by the insurance regulatory and registered as an independent society under the Andhra Pradesh Societies Act. It is a repository of industry data and provides benchmarks for insurance companies.

Under the lead bank model, a bank coordinates the efforts of all lenders in an allocated area and engages with the local administration and state government and address local concerns. This was introduced at the time of nationalisation of banks to fulfil their social objectives.

According to Swiss Re's Sigma report, life insurance penetration (ratio of premium to GDP) was 3.2% while that of non-life was 1%. The world average for life is 3.3% and 4.1% for non-life. In India the life insurance penetration is higher because of high component of retirement savings while the protection component is lower. The regulator has asked companies to achieve G7 level of insurance penetration for life companies and at least double the insurance penetration of non-life companies.

In the meeting Dr R S Sharma, CEO of National Health Authority (NHA), made a presentation on Ayushman Bharat Digital Mission and design of National Health Claims Exchange. The Irdai chairman proposed creation of a working group including the officials of NHA, Irdai and representation from the industry to utilise the claims exchange.

TOP

LIFE INSURANCE

Life insurers' new business premiums grow 4.1% in June to Rs 31,254 cr - Business Standard – 8th July 2022

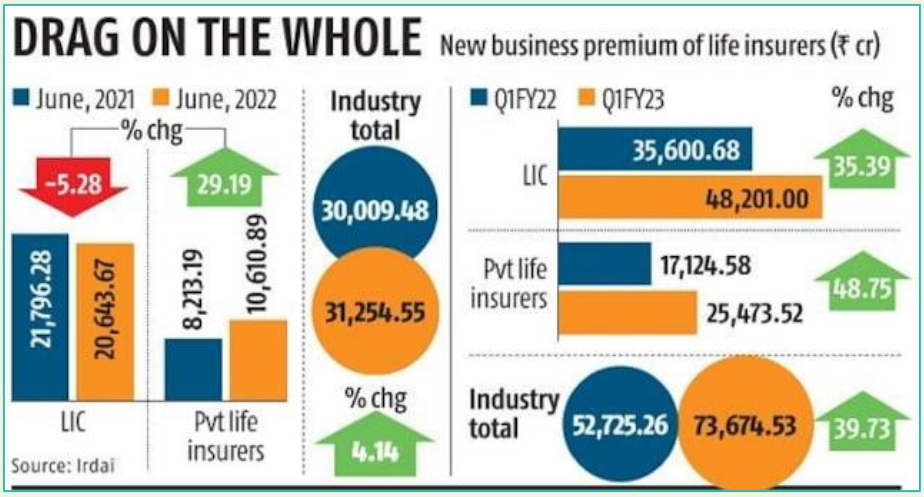
The life insurance industry has reported a meagre growth of 4.15 per cent in new business premiums in June, mainly due to the contraction in Life Insurance Corporation (LIC) premiums. However, in the April-June quarter (Q1FY23) life insurers saw their new business premiums (NBP) rise by 40 per cent over the same period a year ago, on account of lower base.

In June, life insurers netted Rs 31,254.55 crore as new business premiums (NBP) registered a growth of just 4.15 per cent over the same period last year. While private insurers registered 29 per cent growth in NBP to Rs 10,610.89 crore, LIC's NBP contracted by 5.29 per cent to Rs 20,643.67 crore, data by the insurance regulator showed. LIC's drop in NBP can be attributed to a 10 per cent drop in group single premium in June over the same period last year.

An email to LIC to know the reason behind the drop in premium did not elicit a response till the time of going to press. Shares of the corporation closed at Rs 698.15, down 0.7 per cent from the previous day. Among other large insurers, while SBI Life reported a growth of almost 60 per cent in NBP in June, driven by substantial growth in group single premium and individual non-single premium, HDFC Life's NBP rose 11 per cent in the same period. ICICI Prudential Life, however, reported a 14.5 per cent drop in NBP during the same period.

Last year, the first two months — April and May — were marred by lockdowns due to the devastating second wave of Covid-19. But the situation improved June onwards as the economy started opening up. April and May this year saw life insurers recording impressive growth numbers owing to the low base of last year. In April, NBP of insurers increased by 84 per cent and in May it increased 88 per cent. Despite a disappointing June for LIC, in Q1, its NBP rose 35 per cent to Rs 48,201 crore over the same period a year ago. But, private sector insurers outpaced LIC as their NBP increased by over 48 per cent in the same period, resulting in the industry's NBP growing at about 40 per cent.

Experts reckon, the premium growth of life insurers will remain healthy this year, given it's the first year without any restrictions. While it is expected that demand for term, annuity, and guaranteed products will remain healthy, unit-linked products may take a hit, given the volatility in equity markets. "For FY23, we expect private life insurers to grow in the mid to high teens, with LIC growing in high single digits," said Emkay Research in a report.



Non-life insurers

Non-life insurance industry reported a 21 per cent year-on-year (yoy) growth in premiums in June, driven by healthy growth in premiums of private sector general insurers and standalone health insurers. Further, in Q1, the industry netted premiums of Rs 54,492 crore, up 23 per cent YoY.

In June, the gross direct premiums underwritten by non-life insurers, including general insurers, standalone health insurers, and specialised insurers, was worth Rs 17,810.51 crore. General insurers, who operate in different lines of business such as motor, health, crop, etc., saw their premiums rise 19.93 per cent in the month to Rs 15,638.72 crore. Similarly, the five standalone health insurers saw their premiums rise by 32.85 per cent to Rs 2,004.77 crore.

Among large private sector insurers, ICICI Lombard general insurance — the largest private sector general insurer — reported a 54 per cent growth in premiums in June while Bajaj Allianz general insurance posted 13 per cent growth in the same period. Similarly, HDFC Ergo and Reliance General Insurance saw its premium rise 24.5 per cent and 21 per cent, respectively, while Tata AIG General Insurance reported a 35.84 per cent growth in the same period.

Among state-owned general insurers, Oriental Insurance and United India Insurance reported double digit growth in premiums in June while National Insurance reported a de-growth during the same period. New India Assurance, the largest general insurer, reported a flat growth during the same time.

In the quarter, the general insurers posted 22.73 per cent growth in their premiums over the same period last year, while standalone health insurers reported a 28.63 per cent growth.

Segment-wise trends till May suggest that motor insurance is seeing strong growth, albeit on a low base, with a pick-up in auto sales. Also, in health insurance, group health is seeing stronger demand as opposed to retail health. As of May, health premiums grew 24 per cent yoy, driven by 31 per cent growth in the group health while retail health grew 9.6 per cent, on a large base.

TOP

How salary protection insurance can help you – Live Mint – 7th July 2022

Here is a new feature that most life insurers now offer: salary protection insurance. This is a term insurance policy that typically offers a regular income payout option along with a lump sum payment and is also known as income protection insurance.

While opting for such a term insurance policy, you can choose how to divide the total sum assured amount between the two components (regular income and lump sum) at the time of buying the policy. Those who are not investment-savvy or want to choose lower but guaranteed returns can opt for the term policy with a regular income payout option.

Buyers, however, must know that it is a term policy without any maturity benefits. Only the nominee receives an assured death benefit—a lump sum amount—in the case of the policyholder's demise. Akshay Dhand, the Appointed Actuary at Canara HSBC Life Insurance, said as per the terms of the salary insurance policy, regular payments are made to a nominee after the death of the insured for a given number of years.

This is basically a term plan with regular payouts. "This may, however, not appeal to some buyers as the conversion rate offered by the insurer may not be very attractive, considering the guarantees involved," added Dhand.

How this policy works

When you buy a salary insurance or income protection term insurance policy, you have to select the monthly income you want to provide to your family member. It can be less than or equal to your current monthly take-home income. After that, you must select the policy and the premium payment term. For instance, at the age of 30 (for a non-smoker), you can buy a policy for 15 years for a regular premium payment term.

The insurer will decide on the percentage increase in the chosen monthly income by you. For instance, the insurer may offer you a yearly compounded increase of 6% on this income. This means that every policy year, the monthly amount will be 106% of the previous year's monthly income. Let's say that you opted for a monthly income of ₹50,000 when buying the policy. In the second year of the policy, this monthly income will increase to ₹53,000, and thereafter to ₹56,180 the next year, and so on.

Now, let's assume the case of the policyholder's unfortunate demise at the beginning of the fifth policy year. The nominee will get the assured death benefits of ₹7.6 lakh and an increased monthly income of ₹63,124. (Assured death benefit = 12 multiplied by the increased monthly income in fifth policy year = 12 X 63,124 = ₹757,488). The nominee will continue to get the increased monthly income every year for the remaining term of the policy, subject to terms and conditions laid by the insurer.

Rakesh Goyal, director of Probus Insurance Broker, said, "Policyholders should understand that this is a term plan, and salary protection insurance safeguards their family members in case of their unfortunate demise. Such plans offer family members of the deceased a regular income payout option and the lump-sum payment. This will ensure that family members get a monthly income which they can use to continue with their existing lifestyle, spend money on their children's education or marriages."

Mint take

You need to be cautious while opting for such policies as insurers can also sell other variants of life insurance policies in the name of salary insurance.

Term policies that come with critical illness, disability, and even loss of employment cover benefits can also provide you with a regular income in case of unforeseen events. So, if any mishap happens, the

nominee can also get a regular income for a longer period compared to buying a salary insurance term policy, by investing the money wisely.

However, in such a case, the nominee must devise a meticulous plan to use the claim amount carefully after consulting a financial adviser.

(The writer is Navneet Dubey.)

TOP

Integrating ESG into insurance products – Financial Express – 6th July 2022

Companies that address environmental, social, and governance (ESG) issues well are more likely to increase shareholder value, enhance their reputation and contribute meaningfully to sustainable socio-economic development. With customers demanding ESG fund options and information relating to the social impact of their investments, insurers need to ensure that their products and product disclosures meet this demand and that their practices are ethically sound from an ESG perspective.

Here are three ways in which insurers can unlock long-term business value with ESG in the long run.

In efforts to reap rewards, insurers should disclose and promote their respective ESG agenda and work towards sustainability through their operations. Many insurers are developing risk appetites based on net-zero and carbon reduction pathways.

Underwriting decisions

Incorporating climate-related risks in underwriting and investment policies can facilitate the transition towards a cleaner future. Many insurers intend to stop—or have already stopped—providing insurance and risk management services for polluting businesses. To embed ESG into the underwriting cycle, insurers should recalibrate their risk appetite and determine the risks they are prepared to underwrite.

Green products

The impact of ESG variables on product design for both long-term insurance and health care products can be seen. We have seen the introduction of sustainable insurance products from leading Indian life insurers who also have an ESG-focused fund exclusively investing in businesses which are environmentally, socially, and governmentally ethical.

Determining ESG risk appetite

There is a need to determine ESG risk appetite for long-term success. Although there are some areas where traditional insurance coverage addresses ESG event-based incidents, there are many trend-based risks that are emerging within ESG, where insurers need to be more creative in developing solutions to plug a growing protection gap. By assessing which sectors represent the most relevance and risk to the firm, insurers can gain a better understanding of the balance sheet's sensitivity to changes in major ESG risk factors.

The path ahead

Insurers can pave the way for the industry and show how ESG can become part of strategic frameworks rather than just an act of compliance. The goal should not be to just check all the boxes, rather to delve into your company's purpose and create societal value on your core business.

(The writer is Prashant Tripathy.)

TOP

Bundled products convenient, but may fall short of promise: Experts – Business Standard – 2nd July 2022

The Securities and Exchange Board of India (Sebi) recently directed mutual funds to stop offering bundled products. In future, even if you sign up for a long-term systematic investment plan, you will not be offered free life insurance. The financial landscape, however, is full of bundled products. Customers should study their fine print before deciding to rely on them. Bundling happens at two levels.

One is when the product manufacturer offers free additional benefits that are not a standard feature of the core offer. For example, a credit card may offer personal accident insurance to the primary cardholder, or a bank fixed deposit may come with life insurance (for a stipulated period) equal to the deposited amount. In these cases, the product manufacturer pays the premium, or includes it in the core product's pricing.

The second type of bundling happens when the manufacturer offers multiple products or benefits under one umbrella. For example, when you sign up for a home loan, the bank may offer reducing term insurance cover to take care of the loan obligation in case the borrower dies. A personal accident insurance policy could offer reimbursement benefits if hospitalisation occurs due to an accident. In all these cases, an additional premium is charged.

Unit-linked insurance plans (Ulips), which combine life insurance with market-linked investments, are among the most popular bundled products. Bundled products offer a one-stop solution. "They offer convenience, and at times, cost savings. The customer gets two benefits in one product," says Santosh Joseph, founder and managing partner, Germinate Investor Services LLP. Instead of filling in application documents and doing the KYC (know your customer) twice, they have to do so only once. Sometimes the manufacturer bears a portion of the product cost.

Bundled products, however, often come with restrictions. "As they are complimentary in nature, there are always caps on the maximum benefit they can provide. Hence, it is difficult to imagine a bundled product fulfilling a customer's primary needs," says Arvind A Rao, founder, Arvind Rao and Associates. The customer also gets locked into two products at the same time. This reduces her flexibility. "The customer will be forced to discontinue the overall product even if one of them does not work well. Hence, one should be judicious about using bundled products," says Anil Rego, founder and chief executive officer (CEO), Right Horizons.

The free features sometimes come with conditions attached. For instance, insurance cover could cease at a certain age. Product manufacturers sometimes mention in the fine print that they have the right to stop offering the free features at any point, and they do so occasionally. "There could be riders and preconditions linked to the duration or the quantum of the benefit. These could catch the customer off guard," says Joseph. Understand the fine print of these offers. "Most credit cards, for instance, bundle accidental insurance, or insurance for baggage loss, etc.

However, they come with a lot of exclusions that the customer should be aware of," says Rego. Buy a two-in-one product only if it is relevant for you. A personal accident policy may offer hospitalisation benefit after charging an extra premium. However, the sum insured could be inadequate, ranging from Rs 50,000 to Rs 5 lakh. Customers would be better off purchasing a standalone health insurance policy, which would cover hospitalisation for any reason, including accident. "A bundled product sometimes creates the perception that a particular need has been met, when in reality the complimentary benefit may be very low," says Rao. Life and health insurance are non-negotiable products. "Evaluate life and health cover needs as part of your financial planning. While you could use some bundled products, you shouldn't

rely entirely on them," says Rego. Adds Joseph: "Discerning customers should buy separate products. They may be more expensive, but they also offer higher benefits."

(The writer is Sarbajeet K Sen.)

TOP

GENERAL INSURANCE

Phishing in troubled waters? Take cover in cyber liability, say experts – Business Standard – 5th July 2022

Since the onset of the pandemic, and with more people adopting the digital payment route, the incidence of online frauds through malware, phishing, and identity theft has risen worldwide, and also in India. A recent online survey of over 4,500 respondents by PolicyBazaar showed that nearly 20 percent of them had suffered a financial loss due to cybercrime. However, only 24 percent had purchased a cyber insurance policy. The survey also revealed that financial loss due to unauthorised transactions is the threat most respondents (57 percent) want covered through cyber insurance. With more people working from home, the need for a family cyber cover has grown. Soayib Qureshi, associate partner, PSL Advocates & Solicitors, says, "India is second only to China in terms of number of online users, estimated at above 700 million currently. Protection of their data has become a priority." Anyone who's a part of the digital world is at risk in cyberspace.

T A Ramalingam, chief technical officer, Bajaj Allianz General Insurance, says, "We now spend a substantial amount of time on our devices for various daily requirements like mobile and internet banking, online payments, e-commerce purchases, social media consumption, and entertainment on over-the-top platforms." Lovaii Navlakhi, board member, Association of Registered Investment Advisers, says, "Everyone who is exposed to digital platforms needs to protect themselves by purchasing cyber insurance. For those who are more susceptible to frauds, like senior citizens, this cover is a must." New users of the internet are also susceptible. "Cyber insurance cover offers coverage against cyberattacks and threats. It helps customers reduce the impact of losses in case any vital financial, or other sensitive information is stolen or misused," says Ramalingam. Currently, Bajaj Allianz, ICICI Lombard, HDFC Ergo, Future Generali, and SBI General Insurance (which launched its policy on Tuesday) offer this cover.

Naval Goel, chief executive officer and founder, PolicyX.com, says, "The plans are made for individuals. They can be topped up with covers to protect the spouse, children, and other family members." Consider a family cover as nowadays almost every family member goes online. A family floater is also less expensive than buying an individual cover for each member. The covers from various players are broadly similar, although their finer details may vary. Evaa Saiwal, practice leader–liability and financial risk, PolicyBazaar, says, "Some insurers provide specific plans that target different user groups, such as students, entrepreneurs, families, and salaried professionals, while the others offer a personal cyber insurance with sum insured." These policies cover policyholders for losses resulting from fraudulent transactions over the internet, which hit bank accounts, credit or debit cards, and mobile wallets. "Any data breach, ransomware attack, cyberbullying, malware intrusion, or extortion event is covered by this policy. It also covers expenses related to investigation, forensic costs, data recovery, and information technology consultancy services," says Saiwal.

If the policyholder has to consult a psychologist to deal with the trauma or stress arising from such incidents, the cost of doing so is also covered. "This policy generally covers all devices you utilise to

access the internet. Some insurers offer worldwide coverage," says Goel. Cyber insurance policies come with a few exclusions which policyholders should be aware of. "Dishonest and improper conduct, bodily injury, property damage, unsolicited communication, unauthorised collection of data, and immoral or obscene services are not covered," says Ramalingam. Experts suggest buying cyber insurance cover, especially for those working from home (WFH). Kapil Mehta, co-founder, SecureNow, says, "These plans are particularly relevant for people who spend a lot of time online and work using online resources. This segment has increased considerably over the past few years because of WFH. It is a cost-effective cover. For Rs 5,000, you can get a reasonable amount of protection."

(The writer is Bindisha Sarang.)

TOP

HEALTH INSURANCE

Top 15 health plans – Live Mint – 8th July 2022

How do you buy a health insurance plan? If you settle for a plan your agent sells or are happy knowing that you have bought the cheapest one, there is a bit of unlearning and a lot of learning in store for you. On the other hand, with numerous products, plan options, and all the complicated fine print, comparing insurance can be quite a daunting task.

Thus, to simplify and empower quicker decision-making, Mint in association with Beshak.org, an unbiased insurance discovery platform presents Mint Beshak Insurance Ratings. This rating zooms into the most essential aspects of insurance plans blurring out the frills to present a refreshed version 2.0 of our erstwhile Mediclaim rating. In today's edition, we list the Top 15 Health Insurance plans for people below 65. These plans have been first stacked for two critical outcomes with respect to Health Insurance (a) lowest out-of-pocket expenses from hospitalization (Product Rating). The full ratings can be seen here.

	Product rating*	Claims track record rating*	Overall rating	Premium affordability rating
Niva Bupa - Health ReAssure	5	3.7	4.7	3
Royal Sundaram - Lifeline (Supreme Plan)	4.7	3.8	4.5	2.5
Niva Bupa - Health Companion	4.7	3.7	4.5	3
Magma HDI - One Health (Premium Plan)	4.6	4	4.5	4
HDFC Ergo - Optima Restore	5	1.5	4.3	3
Aditya Birla Health - Activ Health Platinum (Premiere Plan)	4.4	3.9	4.3	5
Edelweiss General - Family Health Insurance (Gold Plan)	4.4	3.7	4.3	3.5
Care Insurance - Care	4.3	4.3	4.3	3
ICICI Lombard - Complete Health Insurance (Health Elite Plan)	4.2	4.7	4.3	4
HDFC Ergo - Optima Secure	4.9	1.5	4.2	4
Go Digit - Health Insurance (Comfort Pro Plan)	4.4	3.3	4.2	3
Manipal Cigna - ProHealth (Plus Plan)	4.3	3.9	4.2	3.5
Chola MS - Flexi Health	4.1	4.7	4.2	2.5
Aditya Birla Health - Active Assure	4.2	3.9	4.1	2.5
Star Health - Comprehensive	4.2	3.5	4.1	3.5

*Ratings are based out of 5 stars
Note: The higher the rating, the better the plan is. However, in the case of the premium affordability ratings, the higher the ratings, the more expensive the plan will be.

TOP

Cashless health insurance may not work in case of emergency hospitalisations – Moneycontrol – 8th July 2022

In the past, if you or anyone in your family got hospitalised, you needed to pay the hospital bill out of your pocket first, and then claim for the expenses from the insurer.

The process is called a reimbursement claim. This required you and your family to keep some cash ready at all times -- to pay the hospital for the treatment. However, this was long ago when cashless facility wasn't introduced. Now, insurers have a list of network hospitals where you can get the insurer's early approval that they will authorise your claim and pay the amount directly to the hospital. This process is known as a cashless claim.

The general perception is that once your insurance company offers a cashless feature and you hold a cashless card, you will never have to pay for a hospitalisation in a network hospital, even in case of emergencies. This is not entirely true.

Let's understand the basics first and then I will explain.

What does a cashless claim promise?
The cashless claim process promises easier and quicker claim settlement. One, because there is no need to arrange for large amounts of cash if you're claiming on a cashless basis. And, two, it saves you from the hassle of managing paperwork -- as the insurer and the hospital directly interact and exchange the documents.

How do cashless claims work?
Usually, pre-authorisation is required in case of cashless hospitalisation. So, in the case of planned hospitalisation, this is what the cashless claims process would look like -

- You'll have to inform the insurer about the hospitalisation, recommended treatment, cost of the treatment, etc. through the hospital insurance desk.
- The hospital insurance desk will ask you to submit several documents, like your health card, identity proof, policy documents, etc. They will then submit these documents directly to the insurer.
- The insurance company will evaluate everything and provide a pre-authorisation for the amount that they will pay. A pre-authorisation is an initial promise-to-pay for the patient's treatment. After this, you can get admitted and undergo the necessary treatment at the hospital.
- Before discharge, the hospital desk will send the final bill to the insurer for evaluation. The insurer here will issue a final authorisation that promises to pay the authorised amount to the hospital. The hospital will hence, not recover this authorised amount from you.
- Of course, in case there are certain expenses that are not approved by the insurer, you'll have to pay for these out of your pocket.
- The promise and process above -- all look very relieving -- that you do not have to run around arranging cash, when there is a need for a major hospitalisation.

Unfortunately, it may not hold true in a couple of scenarios, especially during emergencies.

Cashless facility may not work in emergencies
It's important to note that cashless offers convenience but it is not an emergency service. While the cashless process explained above can be applied to emergency hospitalisations too, due to shortage of time, it may often not really work on ground.

Here are two common scenarios we have experienced, where cashless may not immediately work, and hence the need for cash.

Getting the pre-authorisation may take time
Insurers usually take 6 to 24 hours to give their first approval -- the pre-authorisation. They manually evaluate your policy coverage, see if the treatment you need to undergo is covered or not as per the policy conditions, etc.

Now, you won't be able to wait this long during a medical emergency, and hospitals wouldn't process the admission without the pre-authorisation. Hence, despite the availability of a cashless facility, you'll have to make an advance payment at the hospital so that you can get admission to the hospital.

Only when you make the advance payment will the hospital admit you to a room or a ward, and begin the treatment.

The TPA desk at the hospital does not remain open 24X7
Unlike an insurance company or the Third Party Administrator (TPA) that processes claims 24X7, the insurance desk at the hospital that handles the claims may not be open 24X7. They are usually open for 12 hours and may remain closed on holidays. If you are hospitalised during a time when the hospital desk is closed, the hospital will not be able to initiate the cashless claim process until the next working hour. In such situations, the hospital may demand an advance deposit from you to admit the patient and start the treatment.

So, how can you be prepared?
You may not really be happy after reading about this. But here's how you can stay prepared in such scenarios.

1. **In case of planned treatments...**

If your treatment is a planned one, you can visit the hospital and begin the process for your cashless claim beforehand. This way, your cashless request will be approved on the date of admission, and you will not have to make any payment in advance.

2. **Have an emergency fund and a credit card ready**

Always maintain an emergency fund and an active credit card. These will come in handy in case you need to pay an advance to get admitted to a hospital.

Store documents in one place
Keep all documents, like your Cashless Card, Policy Document, Aadhar Card, etc. in an easy-to-access drive folder. This will ensure you or your family have access to all the documents you need for an admission, even in an emergency.

These three things will ensure that you and your family have the best cashless claim settlement experience.

(The writer is Mahavir Chopra.)

TOP

NHA announces successful onboarding of over one lakh govt, private health care facilities in Ayushman Bharat Digital Mission – Financial Express – 7th July 2022

National Health Authority (NHA) on Thursday announced the successful onboarding of more than one lakh government and private health care facilities in the Health Facility Registry of its flagship scheme Ayushman Bharat Digital Mission (ABDM).

"ABDM is the flagship scheme of government being implemented by National Health Authority (NHA). Health Facility Registry (HFR) which is being built under the ABDM is a comprehensive repository of health facilities of the country across modern and traditional systems of medicine. It includes both public and private health facilities including hospitals, clinics, diagnostic laboratories and imaging centers," it stated on Thursday.

According to NHA, ABDM aims to create a seamless online platform that will enable interoperability within the digital healthcare ecosystem. "ABDM has developed building blocks and interoperable APIs (Application Programming Interface) to offer a seamless digital healthcare experience for all stakeholders – health facilities, patients and healthcare professionals. One of the key building blocks is the Health Facility Registry," it added.

"Our aim is to build a trusted national platform where patients can easily get details of registered healthcare professionals and health facilities across the country. We have seen enthusiastic participation of both public and private sector health facilities which have now become a part of this national registry. Patients can easily search the ABDM network for registered facilities across different systems of medicine like modern medicine (Allopathic), Ayurveda, Dentistry, Homeopathy, Physiotherapy, Unani, Siddha or Sowa Rigpa. Similarly, we have the ABHA numbers for patients and Healthcare Professionals Registry (HPR) for professionals like doctors, nurses and paramedics. These national registries will help in making quality healthcare accessible and affordable for all," Dr. R.S. Sharma, CEO, NHA said in a statement.

The NHA also claimed that among the verified facilities, around 97% belongs to government sector. The highest number of verified health facilities are in the states of Uttar Pradesh, Andhra Pradesh, Maharashtra, Bihar, Madhya Pradesh, West Bengal, Chhattisgarh and Assam.

TOP

Buy a health policy that covers treatment at home and pays for consumables – Business Standard – 6th July 2022

A non-governmental organisation (NGO), Manav Seva Dham, filed a public interest litigation (PIL) in Bombay High Court alleging that insurers had been arbitrary in rejecting health insurance claims during the Covid-19 pandemic. The Insurance Regulatory & Development Authority of India's (Irdai)'s counsel assured the court that it would treat the plea as a representation and consider the NGO's grievances. Even as the regulator reviews the cases of claim rejection, the pandemic holds many lessons for health insurance customers, which they should apply both while purchasing a health policy and making a claim. Globally, insurers don't cover catastrophic events like pandemics. Policy provisions in India also stated this. Once Covid-19 was declared a pandemic, insurers rejected claims on the basis of this provision. However, the Irdai issued a notification saying insurers must consider these claims. Insurers then started paying Covid-19 claims.

Another issue that arose around consumables (personal protection kits, gloves, etc). "Prior to the pandemic, consumables accounted for only 5-10 percent of the bill. But during the pandemic their share rose considerably. But since many health insurance policies didn't cover the cost of consumables, insurers didn't pay for them," says Nayan Goswami, head- group business and sales & service, SANA Insurance Brokers. Home treatment was another contentious issue. While some policies covered domiciliary treatment, many didn't. The latter type of policies turned down these claims. Many patients received treatment in makeshift medical facilities. "If the medical facilities were not medically graded, or if people had got isolated in hotels, their claims were rejected," says Nikhil Chopra, chief business officer, Medi Assist, a third-party administrator (TPA).

Initially, doctors used antibody cocktails to treat Covid-19. Insurers refused to bear the cost of such treatment protocols on the ground that they were not scientifically validated. They also turned down requests for reimbursing the cost of vaccination since policies didn't cover this cost. Most policies require hospitalisation for 24 hours for claims to be honoured. Where this condition was not met, claims got rejected. Customers need to understand their insurance policies. "Buyers must carefully scrutinise the

policy features at the time of purchase. And they should have a good idea of what is covered and what is not to avoid unpleasant surprises at the time of claim," says Chopra. The sum insured must keep pace with rising medical costs. "Many people had health policies, but their sum insured proved to be grossly inadequate during the pandemic. Those who had to stay in a hospital for a long duration found that their sum insured got exhausted midway through their hospitalisation," says Viral Bhatt, founder, Money Mantra. Customers should get adequate sum insured for their families based on where they live: those living in a metro should have a higher sum insured than those in a tier-2 or 3 town.

Healthcare needs are changing and insurance policies must keep pace with them. If a customer's policy doesn't, she should migrate to one that offers better features. "Increasingly, one should opt for a policy that covers outpatient department (OPD) and day-care treatment," says Chopra. Pre- and post-hospitalisation treatment should also be covered. Choose policies that cover the cost of consumables and allow home treatment. As far as possible, go to a network hospital and opt for the cashless route (especially if you are undergoing a planned procedure). "In this route, most issues get sorted out prior to hospitalisation. Also, the hospital, the third-party administrator (TPA) and the insurer deal with the paperwork and other issues and the onus doesn't fall on the customer," says Goswami. The reimbursement route is more complicated. The customer needs to fill the right forms. She may have to submit 30-40 pages of documents—reports, vouchers, and prescriptions. These must be filed in the right order. "Incorrect or incomplete submission of documents can lead to claim rejection," says Goswami.

(The writer is Sanjay Kumar Singh.)

TOP

Inclusivity in insurance – The New Indian Express – 6th July 2022

There's always been dialogue and discussion around bringing mental ailments under the scope for health insurance coverage, particularly after the passing of the Mental Health Care Act of 2017 and the aftereffects of the pandemic. However, despite bringing active laws and provisions, the implementation is still a work in progress at a snail's pace.

Throwing light on the ambiguity and reiterating the scope for improvement was an educative panel session presented by the Schizophrenia Research Foundation titled 'Mental Health Insurance Elusive or Inclusive?' on National Insurance Day (June 28). The hour-long interaction was moderated by Dr Mangala, assistant director, SCARF, and A Chiranjeevi, research assistant, SCARF.

The panellists comprised Dr J Meenakshi, consultant ophthalmologist; Narjis Hussain, freelance writer; Sanjay Pinto, advocate; TK Muthu, administrative officer, New India Insurance; and Dr Bhagyam Raghavan, senior consultant, radiology. "We're using this platform not to point fingers at the existing gaps but to see how we can achieve an acceptable solution that's beneficial for all the stakeholders in the long run," began Dr Mangala.

The long road ahead

Offering a ground reality of the mental health status in India, the discussion drew attention to the National Mental Health Survey (2015-2016) by the National Institute of Mental Health and Neuro Sciences. The study revealed that over 80 per cent of persons with depression, substance abuse, or anxiety disorders do not have access to healthcare. While stigma and lack of awareness among the general public always topped the list of reasons, a crucial factor that continues to loom large in front of them is the skyrocketing cost of treatment.

Adding to the distress of patients and their kin, a dearth of mental health professionals in the government sector has only been pushing people to opt for private hospitalisation. A family seeking help for mental health disorder nearly spends Rs 1,000 to Rs 1,500 every month on travel, besides other intangible costs that are not covered. Another study by the World Health Organization found that out-of-pocket expenditure is as high as 62 per cent in India and 32 per cent compared to the global status.

Meenakshi, who struggled to get a health insurance cover when she revealed that her niece had a mental illness and was on treatment, shared, "My niece suffers from a chronic psychiatric illness. Despite having normal parameters on her master health check-up in the past consecutive years, insurance companies refused to provide a cover. I was perplexed and helpless." Responding to this, Sanjay explained, "All insurance companies that do not cover mental illnesses are in violation of section 21 (4) of the Mental Health Care Act 2017 and Insurance Regulatory Development Authority of India's circular number 128 dated August 16, 2018.

The IRDAI should supervise the functioning to ensure there is no discrimination. The right to medical care is every citizen's fundamental right under Article 21, and Article 15 prohibits any kind of discrimination. The companies must be in sync with the law of the land or be liable for contempt of the court. Insurance companies don't seem to be aware of this." There's not much progress even after the Mental Health Care Act came into force in 2018, points out Narjis from her experience of interacting with the stakeholders. "I remember a case where a patient of renowned psychiatrist Dr Harish Shetty was suffering from severe depression and was undergoing treatment at a private hospital.

A doctor herself, she has rejected an insurance claim. Dr Harish took up the issue with IRDAI. When I was following up on this for an article, I spoke to top officials of insurance companies and they said they were not aware of policies that covered mental illnesses. According to psychiatrists, 50-75 per cent of hospitalisation claims filed for insurance coverage are found to be rejected. Clients also seldom follow up. This being a high-profile case, fought by a doctor, got justice. But what about the general public?," she asked.

Mental health matters

On September 30, 2019, IRDAI issued guidelines which barred the exclusion of "mental illnesses, stress or psychological disorders, behavioural and neurodevelopmental disorders" from health insurance policies. Despite this, only a handful of insurers have compiled with the guidelines. Explaining his case, TK Muthu said, "All general insurance policies started including mental health treatment under scope for coverage only after April 2021. We ask the clients to produce results of full body check-ups to keep a tab on their health ailments and transparency from their end. Some policy clauses specify that a customer cannot claim for mental health hospitalisation for the first four years of the coverage period."

Contradicting this, Sanjay opined, "The very basis of any insurance policy is the doctrine of utmost faith. Very often it's the insurance company that throws the hapless rulebook onto the patient. Nobody knows if a condition like dementia is preexisting or not. So prior disclosure does not work in all cases. How many insurance agents who claim commissions for every policy explain the policy fine print to the customers? People take an insurance policy with a legitimate expectation that they will be bailed out on a rainy day. Insurance companies must be transparent and exclusions must be explained carefully. It must be made easy and less cumbersome for a common person." The National Consumer Disputes Redressal Commission has also clearly said that when there's ambiguity in the interpretation of an insurance clause in the policy, the benefit should go to the customer.

Most insurance covers only in-patient treatment for a few days forcing patients to drop out of treatment because of the prolonged expenses. "Policies must be citizen, patient, and customer-friendly. We say we are a welfare state. Pandemic was an example. Insurance is a necessity today and we need to overhaul the way insurance works," reiterated Sanjay. Chipping in, Dr Bhagyam added, "There's no reimbursement for non-hospitalisation treatment, rehabilitation or outpatient services. This naturally means psychological counselling and therapy also gets excluded."

Drawing a comparison to the mental health policies of western countries, Narjis concluded, "The central government's health scheme, Ayushman Bharat, can be availed only by families that are below poverty line and does not cover mental health treatment at private hospitals, while foreign countries provide coverage for all forms of services. These are developed countries and they are aware of the value of mental health. They also know the connection between mental and physical health, and so they spend more on people's health. Health is a state subject in India. The government and state are not coordinating. We hope it evolves and becomes a better scheme for the coming generations."

While it's positive to see some insurers offering support, unless all stakeholders sit together and reevaluate the gaps in mental health insurance coverage, we may not be able to make much progress.

The laws

According to Mental Health Care Act 2017 section 21 (4), every insurer shall make provision for mental insurance for the treatment of mental illness on the same basis as is available for the treatment of physical illness.

Health insurance companies can be prosecuted under section 109 of MHCA 2017 for not following section 21 (4).

The Insurance Regulatory and Development Authority of India issued circulars in 2018 and 2020 to include mental illness under insurance coverage.
Source: SCARF

Did you know?

Self-inflicted injuries and suicide attempts are not covered by the available health insurance policies. Recently, court litigations have highlighted the non-compliance of insurance companies in considering mental illnesses on par with physical illnesses.

(The writer is Vaishali Vijaykumar.)

TOP

MOTOR INSURANCE

IRDAI permits "sophisticated" usage-based add-ons to basic motor insurance policies – Financial Express – 7th July 2022

The country's insurance regulator Insurance Regulatory and Development Authority of India (IRDAI) has permitted general insurance companies to introduce tech-enabled concepts for the Motor Own Damage (OD) cover in order to offer customers usage-based insurance covers as add-ons to the basic policies of Motor OD.

Issuing a circular on Wednesday, the regulator said the concept of motor insurance is constantly evolving and as a step towards facilitating technology enabled covers, it is allowing the general insurers to bring in sophisticated add-ons such as– "Pay as You Drive" and "Pay How You Drive"– to Motor Own Damage policy. The regulator has also allowed the insurers to introduce floater policy for vehicles belonging to the same individual owner for two-wheelers and private cars. This circular will come into effect immediately.

"Introduction of the above options will aid in giving the much needed fillip to Motor OD Insurance in the country and increase its penetration," IRDAI said in a release.

According to general insurance industry insiders, introduction of add-ons covers like “Pay as You Drive” and “Pay How You Drive” will nudge customers towards a utility based “Pay as you Use” model, lending greater flexibility and convenience in customer choice. Moreover, the usage-based covers as an add-on to an OD policy will give additional protection for those customers who have a lesser frequency of vehicle usage. “This is a very positive development. The add-ons to the basic policies of Motor OD will allow a purely asset-based rating mechanism to a mechanism which encourages better driving behaviour and optimum usage. Policy premiums would certainly reduce for customers who drive better and use cars less,” Sanjay Datta, chief — underwriting, claims and reinsurance, ICICI Lombard General Insurance, told FE.

Datta said introduction of the floater policy for vehicles will allow customers to put several vehicles together under a single policy. “Gathering data for introducing such add-ons would not be a problem for insurers. There will be a lot of partnerships among different stakeholders. Nowadays there are a lot of apps which can be utilised by the insurance companies. So, technologies are there to implement some of these things now,” he pointed out, adding ICICI Lombard will “definitely” be looking into bringing in such add-ons to the basic policies of Motor OD.

Udayan Joshi, president – Underwriting & Reinsurance, Liberty General Insurance, said it was a welcome move by the regulator, especially at a time when the pandemic has changed the way people work and travel. And, these add on covers will definitely appeal to the customers who are working from home more often, thus making car insurance cost effective for them. Further, this will give lower mileage drivers more transparency and control over their auto insurance. “At Liberty General Insurance, we have tested the product concept of ‘Pay as you drive’ under the regulatory sandbox, and feel excited about the opportunity. Further, the introduction of add on covers such as these will also act as a catalyst in deepening the penetration of Insurance in the Country,” Joshi said.

According to T.A Ramalingam, chief technical officer, Bajaj Allianz General Insurance, customers do not necessarily use their vehicles in a similar manner where some customers may have a lesser frequency of vehicle usage or prefer to use public transport or organizational transportation facilities. Hence, this is where he felt IRDAI’s circular on motor insurance add-ons, which is principally a usage-based cover as an add-on to an OD policy, gives additional protection for those customers who have a lesser frequency of vehicle usage or also based on the driving pattern of the insured.

“The IRDAI circular seems very customer centric and positive move by the regulator. While exact product details would emerge later, this should cheer up the customer confidence and sentiment,” said Susheel Tejuja, principal officer, founder & managing director – PolicyBoss.com. Tejuja said introduction of covers such as “Pay as you Drive” and “Pay How You Drive” will nudge customers towards a utility based “Pay as you Use” model, lending greater flexibility and convenience in customer choice. Currently, there is price equity due to lack of user behavior based pricing of insurance premium, which will change. This will make it cost effective for low usage customers especially ones who drive less than 10,000 kms a year.

On the flip side, Tejuja, said such a move will eliminate the cross subsidy currently enjoyed by high usage customers, possibly resulting in slightly higher premiums for this set. “How it adds to complexity in claims will emerge once insurers release product details. Overall, these covers seem to encourage good driving and usage based pricing, which should augur well for the customers,” he said.

Industry observers said the ability to cover multiple vehicles under a single policy will greatly aid the convenience factor, by eliminating the need to hold individual vehicle policies and track their renewals. And, this should also aid in increasing product penetration for private car and two-wheeler insurance on the whole and effect lower lapsation and renewal defaults by customers. However, the lump sum amount payable for single premium of multiple vehicles may pinch a few and it remains to be seen how the claim process is set for this cover.

(The writer is Mithun Dasgupta.)

TOP

Motor insurance: For a smooth ride in the monsoon – Financial Express – 4th July 2022

The monsoon rainfall has started, and so have traffic jams, waterlogging and reduced visibility. While the rainy season is a good time for a cuppa and a long drive, one also needs to be overly cognisant of the vehicle's safety. If we talk about the state of road accidents in India, the stats are alarming. As per the recent report by the World Bank, India only has 1% of the world's vehicles but ranks the highest when it comes to deaths by road accidents. The vulnerability of such risks only tends to get higher during the monsoon.

To protect vehicle owners against mishaps, the law has made third-party motor insurance mandatory. For new car owners, the rule mandates a one-year comprehensive plus three-year third-party policy while buying a car. In the second and third years, the customer just needs to buy a standalone own damage (SAOD) policy. But this provides only a partial shield. An accident, specifically on slippery road conditions, can cause damage beyond that. Therefore, opting for comprehensive insurance and upgrading the add-on riders ensures guaranteed extended safety.

Here are a few valuable riders that should be a part of your motor insurance policy this monsoon:
Engine protection cover
An engine is one of the most vital elements as it powers the vehicle. Yet the non-accidental damage to it doesn't get covered under the basic policy, not even in a comprehensive one. Consequently, getting this rider, especially for a country like India that has varied climatic conditions, becomes vital. Insurance companies provide hydrostatic coverage as part of this rider to protect against the outcomes of consequential losses. For instance, during heavy rains, if your vehicle gets plunged into the water and the engine suffers water ingression, the engine protection rider will come in handy. Especially if you have a new car, you must get this cover for long-lasting engine life. It also protects from other standard issues like oil spills, leaking cooling system parts, etc.

Nil or zero depreciation cover
A car's worth depreciates with every passing day. Even on the next day of purchase, it devalues by about 5%. Thus, when filing a claim, insurance firms will regard the declined value of replacement parts as the current value and compensate you accordingly. However, by purchasing this commonly known bumper-to-bumper cover, you can redirect the depreciation liability of your wheels and their parts to the insurance company. Furthermore, a zero depreciation add-on rider guards all vehicle components at 100% except for tubes, batteries and tyres, which are covered at 50%.

Consumables cover
When purchasing a car, we are often mindful of certain expenses beforehand. These are tyre changes, regular maintenance, etc. However, a car is intricate machinery that requires consumables like bolts, screws, coolant, lubricant, grease, etc, to help its four-wheeled, sturdy metal body run smoothly. Therefore, by adding the consumables rider to a comprehensive car insurance policy for up to a 60-month-old car, you can get reimbursed for expenses incurred on these parts during their repair.

Tyre protection cover
Your car runs on wheels, so never compromise on the tyre protection. The tyre protection cover protects your wheels against risks like tyre bursts, cuts, labour charges for refitting, etc. Also, when the traction is severely compromised during heavy downpour, having a sturdy wheel band becomes paramount. This, however, will not cover minor puncture repairs, manufacturing defects, rebalancing, and alignment of tyres.

No-claim bonus protection cover

A no-claim bonus (NCB) is a reward from the insurance company for taking extra care of your vehicle. By not filing a single claim during the entire tenure of the policy term, the insurance company offers you an attractive discount or lower premiums when renewing or porting the policy. But this bonus stands nil even if you file a small claim. So, by opting for NCB protection cover, you can keep the NCB benefit intact even if you make a claim. One stands to earn up to 20-50% for up to five claim-free policy years, so this is a valuable add-on for you, especially if you are a seasoned, careful driver.

To conclude, your vehicle is your companion on good or bad roads. While it protects you from certain hazards, it is equally crucial or you to ensure its safety as well. Therefore, don't forget to add these suitable supplementary covers to have a smooth ride this monsoon.

(The writer is Ashwini Dubey.)

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PENSION

NPS schemes will indicate risk profiles from July 15: Get details here –4th July 2022

The Pension Fund Regulatory and Development Authority (PFRDA) issued a circular last month that lays out rules on informing investors about the risk profiles in NPS investments. This will help NPS subscribers to make more informed decisions regarding the allocation of their contributions to various asset classes.

According to a circular dated May 12, 2022, "It has been decided by the Authority that Pension Funds managing the Tier I & Tier II Schemes of Assets Classes Equity (E), Corporate Debt (C), Government Securities (G) and Scheme A, shall maintain and disclose risk profiling of the Schemes in accordance with the following guidelines.

The Risk profiling will have following six levels of risk for the schemes:

- Low Risk
- Low to Moderate Risk
- Moderate Risk
- Moderately High Risk
- High Risk, and
- Very High Risk

Where to check risk profiling

The risk profiling will be disclosed on the websites of the respective Pension Funds under the 'Portfolio disclosure' section within 15 days of the end of each quarter-ending month.

Funds eligible for risk profiling

The Authority has ruled that Pension Funds managing Tier I and Tier II Asset Classes Equity (E), Corporate Debt (C), Government Securities (G), and Scheme A must keep and disclose risk profile of the Schemes.

Debt risk profiling

According to the circular, "Based on the conservative credit rating of the instrument, the credit risk values ranging from 0 to 12 shall be assigned. A credit value of 0 indicates the highest credit quality, while credit value of 12 indicates lowest credit quality. The credit risk score of the portfolio shall thus be

arrived at by aggregating the product of credit risk value of the securities and their allocation in the portfolio."

The NPS Trust will review risk profiling on a quarterly basis, and any modifications will be disclosed on the websites of the Pension Funds as well as conveyed to the NPS Trust for updating.

The risk level of the plans as of each year's March 31 and the number of times the risk level has changed throughout the year will be published on the websites of pension funds.

This circular will be effective on July 15, 2022, for all existing schemes in categories E, C, G, and A.

Pension Funds may, however, choose to implement the provisions before the effective date.

(The writer is Sneha Kulkarni.)

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IRDAI CIRCULARS

Topic	***Reference***
New business data as at 30.06.2022 (line of business wise)	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4752&flag=1
New business statement of life insurers for the period ended 30th June,2022	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4751&flag=1
Sophisticated Add-Ons to Motor - Own Damage policy	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4750&flag=1

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GLOBAL NEWS

China: Solvency ratios of insurance sector remain in appropriate range under C-ROSS Phase 2 – Asia Insurance Review

China's insurance sector maintained steady operations and reported adequate solvency in the first quarter of this year, the country's banking and insurance regulator has said.

The average comprehensive solvency ratio of the 180 insurers reviewed at a regulatory meeting was 224.2% as of 31 March 2022, and their average core solvency ratio was 150%, said the CBIRC.

Branch	Comprehensive solvency ratio %	Core solvency ratio (%)
P&C insurers	236.3	204.2
Life insurers	219.3	136.6
Reinsurers	298.5	267.5
Average	224.2	150.0
Required minimum ratio for an insurer	100.0	50.0

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The average comprehensive solvency ratio of the 180 insurers reviewed at a regulatory meeting was 224.2% as of 31 March 2022, and their average core solvency ratio was 150%, said the CBIRC.

The 31 March 2022 solvency data are monitored closely because the January-March quarter of this year was the first quarter for which insurers adopted the new China Risk-Oriented Solvency System (C-ROSS) Phase 2 in their financial reports.

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