Insurance Institute of India
C – 46, G Block, Bandra-Kurla Complex, Mumbai – 400051

INSUNEWS
- Weekly e-Newsletter

15th – 21st September 2018

• Quote for the Week •

"Happiness is an attitude of mind, born of the simple determination to be happy under all outward circumstances."

J. Donald Walters

INSIDE THE ISSUE

Insurance Industry

India Post invites proposal for consultancy on setting up insurance arm - Financial Chronicle – 20th September 2018

India Post has invited bids to appoint consultant for consultancy on setting up separate insurance services arm, according to official sources.

"The consultant will prepare project report on setting up of Postal Life Insurance (PLI) Strategic Business Unit (SBU), impact assessment, conversion into government owned independent company within Department of Posts (DoP) and overseeing implementation thereof," the source said. The pre-bid meeting in this regard was held on September 18.

"All known players- Boston Consulting Group, PricewaterhouseCoopers, Ernst and Young, KMPG, Deloitte India etc. were present," the source said.

Communications Minister Manoj Sinha early this month told PTI that the DoP has plans to set up insurance firm as a special business unit in two years.

At present, the postal department offers one of the oldest life insurance schemes for benefit of government and semi-government employees — Postal Life Insurance (PLI), which was introduced in 1884.

Rural Postal Life Insurance (RPLI), introduced on March 24, 1995, provides insurance cover to people residing in rural areas, especially weaker sections and women living in rural areas.

As on March 31, 2017, there were 46.8 lakh PLI and 146.8 lakh RPLI policies across the country.

Source

Back

Risk for brokers; lower bancassurance income to cut pvt banks' earnings -Financial Chronicle – 20th September 2018

The market regulator Sebi's decision to shrink total expense ratio (TER), which should be effective in 2-3 months, could impact sector earning by 25 per cent and could lead to a 15-25bps reduction in equity fees, while the change in debt fees is unlikely to have a material impact. The equity AMUs form 40 per cent of total funds.

Companies plan to pass on the majority of this to distributors and this will be key in defending earnings. The shift in the payment of brokerages from a mix of upfront and trail to pure trail will help reduce investor churn and also the improve working capital cycle. However, some knock-on impact for brokers and private banks, which are distributors of mutual funds, were also seen. Hence, a potential risk arises for life insurers in the case Irdai or Insurance regulatory development authority of India reviews fees on Unit Linked Insurance Plans (Ulips).

Moreover, industry interactions indicate that AMCs plan to pass on a majority of this reduction to distributors through a cut in brokerage. In this context, it is interesting to note that in mid-2018 when Sebi cut equity fees by 15bps, the industry passed on 70-100 per cent of the impact to distributors. AMCs' ability to pass on the impact

to distributors will be key to their ability to defend the earnings impact. If they pass 50 to 70 per cent of impact then the impact on earnings would moderate to 10 per cent.

The conversations with the industry persons indicate trail-based commissions may also reduce churn amongst customers. Additionally, the shift in brokerages from a combination of upfront and trail to pure trail fees would also improve the working capital cycle for AMCs as the entire brokerage will be paid out over a year versus the current practice of 60 per cent being paid up-front. From an accounting perspective at the AMC level, reported revenue and brokerage costs could see sharper declines as all brokerage costs would be borne by the scheme itself and only net revenue and costs would flow onto AMC P&Ls.

Significantly, a cut in distribution fees would also be a risk for brokers. For I-Sec, mutual fund distribution fees form 15 per cent of revenue and a 10bps cut in fee could impact FY19 PBT by 4 per cent. Private banks are also large distributors of mutual funds and cold see some impact on their earnings due to lower bancassurance income. While this regulation does not impact the insurance sector, a cut in fees for Ulips could also impact insurers' profitability, although, so far, there is no discussion on this aspect.

Source

Back

No catastrophe cover this year - Financial Chronicle – 17th Sept 2018

Despite demands from all quarters, including general insurers and reinsurers, the much sought after catastrophe insurance is unlikely to be implemented in the current fiscal. Keeping an eye on 2019 polls, the government has asked the finance ministry to focus on flagship schemes on health cover for the poor.

Confirming the development, a top source in the finance ministry told FC, "There is no new insurance product, including catastrophe cover in the government's menu this fiscal. We have been told to speed up the ongoing government's flagship health schemes such as Ayushman Bharat, Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY) and Pradhan Mantri Fasal Bima Yojana (PMFBY)."

At a time when insurance is increasingly seen as a social security, a demand is being raised that the government should provide catastrophe cover not only to assets and properties owned by it but also to the people as a whole, on the lines of schemes such as Ayushman Bharat, PMJJBY, PMSBY and PMFBY.

It can happen only by having parametric cover by states. "The election year has already started and we are focusing on these pro-poor schemes in the country. We are continually reviewing each scheme on regular basis and we are trying to meet the government's targets set in these schemes," said the source.

Early this year, general insurance companies had presented their case to the finance minister. "The ministry sat with the insurers' paper for a long time and could not take any decision in this regard. The ministry wanted a debate among insurers, the sector regulator and all stakeholders, before going for the plan but it could not happen due to some reason or the other," the source added.

Besides, it added, non-life insurance firms also had presented a concept paper on catastrophe insurance to the National Disaster Management Authority (NDMA), highlighting the need for a pool mechanism to deal with losses from catastrophic events. "However, it was put on hold because there was no consensus between the insurers and NDMA on who would fund the process and how the pool will function. In the absence of such a pool, both insurers and reinsurers have to bear the cost, leading to a big hit on their profitability."

As per the government, catastrophe health cover is a scheme that meets the requirements of other qualified health plans (QHPs), but do not cover any benefits beyond three primary care doctor visits per year before the plan's deductible is met. The premium paid each month for healthcare tends to be lower than for other QHPs, but the out-of-pocket costs for deductibles, co-payments, and coinsurance are typically higher.

The industry experts, however, said that both the general insurance council and NDMA need to discuss each of these issues in detail and decide on the nature and pricing of this cover. "In that case, it might take a year or half for it to be implemented," they added.

"As far as the cover is concerned, at least over 60 per cent of the risks would have to be reinsured, to enable them to provide cover. Since the risks associated with this segment are very high and we do not have the pricing and pool mechanism in place, reinsurers are not very comfortable in taking a big exposure in this segment in India, at present," said a chief of a private general insurer.

A pool-based concept for natural catastrophe events was first mooted by the finance ministry and later backed by the general insurers. If a pool is formed, on the lines of the terrorism-pool in India, the losses would be distributed evenly. The pool would consist of regular premiums being made by the common citizens, with or without additional government funds infused in it.

Prabodh Thakker, chairman, Global Insurance Brokers, said, "Worldwide, governments are witnessing increasing trends of catastrophic risks to government assets either due to natural catastrophe or man-made disasters. Indian institutions are no different to it from its world peers, as our country continues to be accident or disaster prone society. Added complexity is due to rapid urbanization and ever-growing migration to urban city centers from rural areas."

The recent flood in Kerala should provoke many state governments and the central government to think about a holistic approach towards protecting government assets and revenues through its various agencies – be it municipal corporations or various state boards etc. "It's time for government agencies to give a serious consideration to protect its assets and revenue through proper process of risk identification, evaluation, retention and transfer," said Thakker.

Source

Back

'Insurers have too much say in picking ombudsmen' – The Times of India – 17th September 2018

Of the nine-member body that supervises and administers the office of the insurance ombudsman, seven are representatives of insurance companies. This means that the Executive Council of Insurers (ECI) that plays a crucial role in the appointment of ombudsman is not an "independent and impartial body" but one "led by the insurance industry", pointed out National Institute of Public Finance and Policy in its report on the health insurance sector. The report added that even the office of the ombudsman is funded by the insurance industry.

"Insurance companies should have no role in the selection and administration of the insurance ombudsman… Because insurance companies are interested parties in disputes with the insured. An industry-led insurance ombudsman implies that insurance companies act as judges in their own cause," stated the report.

The nine-member ECI has just two members from the Insurance Regulatory and Development Authority of India (IRDAI) and the Centre. Though the law was reformed in 2017 to have a separate selection committee for ombudsman, the ECI decides both selection criteria and shortlisting of eligible candidates for the said committee. The report noted that in contrast, the financial ombudsman in UK, for instance, does not include any financial service provider, including insurance companies, on its board.

Apart from the problem of independence, there are too few insurance ombudsmen, just17 for the entire country. In March 2018, all offices of insurance ombudsmen lay vacant, the report Fair Play In Health Insurance In India observed. Some lay vacant for two to three years in 2017 resulting in a large backlog of cases.

The ombudsman post in Mumbai, for instance, lay vacant for two years, between 2016 and 2018. Nine of the 17 posts (Delhi, Ahmedabad, Bhubaneshwar, Ernakulam, Kolkata, Lucknow, Noida, Patna and Pune) are still vacant.

As per the report, IRDAI regulations have no procedure to settle claims or redress consumer grievances against rejection of claims. Regulations merely lay do by leaving the detailed procedure for settlement to companies, every insurance company has developed its own procedure to redress consumer grievances. Consequently, health insurance disputes are not settled in accordance with the law but in an ad-hoc manner," noted the report.

The report cited the case of Virender Dhiman to show insurance companies face no consequences for rejecting valid claims. Dhiman's mother was hospitalized after taking a fall. The insurance company rejected his claim saying his mother did not need hospitalization despite the insurer approved hospital having certified that she did. In the consumer court, the insurer did not even appear to defend its rejection.

While the claim amount rejected was Rs 80,461, the insurer was fined just Rs 5,000. With no penalties for rejecting valid claims, insurance companies seem to violate regulatory requirements without any repercussions, stated the report.

"The fact that these violations are persistent shows that penalties do not act as deterrence... To act as deterrence, there is need to ensure the violator pays a fine higher than the gain made through the violation. The penalty should be a multiple of the illegitimate gain from the violation," it said.

Source

Life Insurance

Life insurers seek separate investment window in income-tax deduction - The Hindu Business Line – 19th September 2018

Life insurance companies have urged the regulator to work out a special investment window for their products.

The issue was raised at a recent meeting of the Life Insurance Council with Subhash Chandra Khuntia, Chairman, Insurance Regulatory and Development Authority of India.

"Life insurance products have a long investment period and need focused attention. They should not be clubbed with other investments under the Section 80 C Income Tax limit," said an official, who attended the meeting, adding that life insurers have sought a separate annual investment window of at least Rs 50,000.

Sources said that Khuntia has asked the life insurance industry to finalise a formal proposal that can be taken to the Finance Ministry for further discussion.

The government offers an additional tax deduction of Rs 50,000 for investment in the National Pension System, and insurers say that a similar facility should also be extended to life insurance products.

Life insurers have also pointed out that unlike general insurance products such as third-party motor insurance, which is mandatory, most life insurance products do not have a sufficient "pull factor" and fail to attract the interest of consumers.

Similarly, the 2018-19 Union Budget also increased the deduction for health insurance premium and medical expenditure under Section 80 D for senior citizens to Rs 50,000 from Rs 30,000.

"Life insurance products are, however, important investments and have a huge potential given the large under-penetration of these products in the country," said the executive.

Currently, Section 80 C of the I-T Act provides a deduction of Rs 1,50,000 to the total annual income of an individual for long-term investments such as the public provident fund, Employees' Provident Fund, National Savings Certificates, unit-linked plans and life insurance.

While life insurers are optimistic after their discussions with the IRDAI chief, the move could be some time away due to the general elections early next year. Any such tax deduction would have to be introduced as part of the amendments to the Finance Act, along with the Union Budget.

Source

The current government is likely to table only an Interim Budget and the Full Budget for 2019-20 will be presented by the new government after elections.

Back

Anganwadi, ASHA workers to get free insurance cover soon, says Labour Minister Santosh Gangwar - Financial Express – 17th September 2018

Labour Minister Santosh Gangwar said Monday that Anganwadi and ASHA workers would soon be getting free life and accident insurance under the PMJJY and PMSBY schemes. "We would provide free of cost insurance (under PMJJY and PMBSY) to these workers (Anganwadi and ASHA workers)," Gangwar said at a function to distribute Vishwakarma Rashtriya Purusar (VRP) and National Safety Awards (NSA).

"The honorarium of 14 lakh Anganwadi workers have been increased from Rs 3,000 per month to Rs 4,500 per month. Likewise, honorarium of Anganwadi helpers has also been increased from Rs 1,500 to Rs 2,250 per month. There are over 10 lakh ASHA workers."

The Pradhan Mantri Jeevan Jyoti Yojana (PMJJY) and Pradhan Mantri Suraksha Bima Yojana (PMSBY) provide life and accident insurance cover of Rs 2 lakh each, respectively. The annual insurance premium of the PMJJY is Rs 330 while it is Rs 12 for the PMSBY.

Earlier this month, Prime Minister Narendra Modi announced over 50 per cent hike in honorarium of Anganwadi and ASHA workers.

Stressing that the government is committed to labour reforms, Gangwar said, "We are expecting standing committee's report on Wage Code Bill soon. The Code on Social Security has also been circulated for discussions on our website. The two other codes are also at various discussion stage."

Under labour reforms, the government wants to concise 38 labour laws into four broad codes. The minister said that workers of the country are architects of modern India. He gave away 28 Vishwakarma Rashtriya Puraskar (VRP) shared by 139 individuals and 128 National Safety Awards (NSA) for the performance year 2016 at a special function at New Delhi today. Addressing the function Gangwar said that there are around six crore organized sector workers who are getting benefits of EPFO and ESIC.

He said that Prime Minister Narendra Modi is specially concerned about around 40 crore unorganized sector workers. The Union Government has taken many steps to enhance their working conditions, safety and social security in order to improve their standard of living. On building and construction workers' cess, he said, an amount of Rs 40,000 crore has been collected as cess for welfare of construction workers and this fund is being utilized by states for welfare of nearly 5 crore construction workers.

He said, "Our government is concerned for well-being and safety of women workers too. Recently, Creche facility for the organisation with 50 or more workers has been made compulsory. Maternity leave has been extended up to 26 weeks from 12 weeks." He further said, "Ministry is making efforts to increase employment opportunities through Pradhan Manrti Rojgar Protsahan Yojana. Twelve per cent of the Employees' Provident Fund (EPF) contribution of new employees is being given by government so that employees may not have to bear this cost and enhancement of employment opportunities. The government has spent Rs 1,744 crore for this EPF contribution for around 72 lakh employees of nearly 87,000 organisations."

Source

Back

Health Insurance

Modicare: Premium to be capped at Rs 1,110 - Financial Express – 20th September 2018

The Centre will likely cap annual premium outgo for the ambitious Pradhan Mantri Jan Arogya Yojana (PM-JAY) at Rs 1,110/family, to provide Rs 5-lakh-a-year health cover to 10.74 crore households. The Niti Aayog had earlier estimated the premium at Rs 1,000-1,200. Between them, the Centre and states will share the scheme's estimated annual cost of around Rs 12,000 crore in a 6:4 ratio.

According to sources, the cap on premium will be applicable for both the trust and insurance models for the scheme. A notification in this regard is expected shortly.

Since two-thirds of 30 states on board have opted for the trust model, the ultimate burden on the exchequer could be higher, a state government official said.

If the claims paid out to hospitals under the trust model are greater than the Centre/state government contributions, the losses will have to be shared between them; in the insurance model, any extra payouts are borne by the insurer.

Officials reckon that annual PM-JAY burden on the Centre would be Rs 7,153 crore, much lower than anticipated by many analysts. Since the scheme will be implemented in the second half of this year, the cost in 2018-19 could be about Rs 4,000 crore. So, with an additional allocation of Rs 2,000 crore (in the first supplementary demand for grants in July this year) over the Rs 2,000 crore allocated in the Budget under the head of Rashtriya Swasthya Bima Yojana, the Centre has technically made the provisions to fully fund the scheme in 2018-19.

However, the premium costs have already crossed the proposed cap in the small number of states where a limited insurance model is being used. Some states like Chhattisgarh are offering a "hybrid" model where insurance companies will pay for claims made below Rs 50,000/annum per family; claims above this and below Rs 5 lakh will be dealt with by the "trust". The bid for Chhattisgarh's "hybrid" model was won by Religare Health which put a bid of Rs 1,100 per family. The winning bid of Rs 1,100, though, means insurance costs have risen quite a lot since Rajasthan's existing Bhamashah scheme offers a cover of Rs 5 lakh for a premium of Rs 1,263 while Chhattisgarh's scheme offers just a Rs 50,000 cover.

In India, the citizens' out-of-pocket (OOP) expenditure on health constitutes 62% of the total expenditure on health. For PMJAY, over 8,000 hospitals have offered to join the network of empaneled facilities that would provide inpatient care to the identified beneficiaries. As many as 1,350 medical packages, covering surgery, medical and daycare treatments, have been identified so that the coverage includes most of the common medical conditions.

Source

While the pilot of the PM-JAY was launched on August 15, Prime Minister Narendra Modi will formally launch the scheme from Ranchi on September 23. The scheme aims to provide free secondary and tertiary treatment to about 50 crore deprived people or 40% of the total population of the country and is seen as a big pro-poor initiative ahead of general elections next year.

Back

Jan Arogya Abhiyan: Much more than a health insurance programme – Financial Express – 20th September 2018

The Pradhan Mantri Jan Arogya Yojana Abhiyan (PMJAY) is viewed differently by different people. To a potential beneficiary, it is an entitlement for hospital care. To a social scientist, it is an anti-poverty programme as well as a programme aimed at improving the health of the poor. To a politician, it is a populist programme that is aimed at garnering voters' support in the forthcoming assembly/general elections. To a health planner, it is a significant step towards achieving Universal Health Coverage. To a systems specialist, it is a programme aimed at fixing the country's health system.

It's not just insurance

On the face of it, PMJAY is a programme for supporting demand for hospital care by providing financial protection of Rs 5 lakh per household to almost 10.7 crore poor households against hospitalization costs. In reality, it is much more than that, as it is also aimed at developing the market, especially in areas where hospital care is almost non-existent or is in short supply. In other words, PMJAY deals not only with making hospital care financially accessible for the poor, but also making such care available in closer proximity to where the beneficiaries reside.

To improve the hospital care infrastructure in rural areas—where nearly 76% of the total beneficiaries reside—the government has a two-pronged strategy: to strengthen public hospitals at district and sub-district levels, as well as to forge partnerships with the private sector to augment supply in the under-served areas.

For strengthening of public hospitals, the government has rightly prioritised those districts having a higher share of potential beneficiaries and lacking in hospital infrastructure. On forging partnerships with the private sector, the government is encouraging private providers to partake in this national mission.

In tier-1 and in most tier-2 cities, hospital care is reasonably well-developed. In these cities, private players can decide whether or not to join the scheme, given the rates being offered by the programme. Depending on their cost-structure and the target-market segment, some private hospitals will choose to stay out, while others may opt in, which is fine.

Private providers

The real challenge is in getting the private sector to establish new hospitals in tier-3 cities and in rural areas. In these places, new hospitals need to be established, and the numbers are not in the hundreds, but in the thousands. By the government's own admission, the shortfall in hospital beds is around two-thirds of the number required for the scheme to operate at full scale. However, for encouraging the private sector to set up new tertiary hospitals in tier-3 cities and rural areas, the government needs to reach a much better understanding with them, with a longer-term perspective.

The market mechanism is not a good enough guide for the private investor to enter the under-served areas. Why is this so? The government-supported demand would be the prime mover of private investments in hospital care in these areas. Therefore, a return on private investment is critically dependent on the package rates that the government would pay. It is true that private hospitals joining PMJAY would gain recognition that would help them tap the "residual" market that could be charged higher rates, but there is a lot of uncertainty around this. There are indications that the advantage of package rates would also be extended to the above-poverty line population over time.

So, package rates that have been set for now and about which the private sector is already complaining are central to the private sector play. Even though the government has promised a detailed review of these rates in the future, there ought to be a clearer understanding now on the principles to be followed while reviewing and revising the rates in the future.

Additionally, the government would likely need to extend other incentives by way of concessional loans, single-window clearance to comply with the various regulatory requirements and so forth. Also, there would need to be a clear understanding on the "sunset" provisions of these incentives. In short, both the sides need to ask the question of how they see this public-private partnership evolve over, say, the next 10 years, and accordingly need to arrive at a longer-term understanding.

Full potential

Although the private sector has an important role to play for the success of this programme, the programme's success is not to be measured by the success of the public-private partnership or by the extent of the financial protection it provides. Undoubtedly, these are the key indicators of success. But its success is also to be measured by the extent to which the programme realises its full potential. The programme has the potential to improve efficiencies in public hospitals, to encourage the use of low-cost technologies to make hospital care affordable, to carry out reforms in the upstream areas such as medical education and training, to narrow down geographical inequities in the distribution of health infrastructure through incentives and regulations and so on and so forth.

Harnessing these complementarities is essential for the realization of the full potential of the programme.

Therefore, PMJAY has all the necessary ingredients needed for its success—a strong leadership support, good initial design, assured public funding, support from the states, and the needed momentum. Those engaged in the operationalization of the programme also need to pay heed to realising its full potential from the health systems perspective. Let the urgency of operationalization not get in the way of doing things that are important if the programme is to be truly transformational.

Source

Back

Indian healthcare is poised for a great leap forward with Ayushman Bharat – which will insure over 50 crore citizens – The Times of India – 20th September 2018

Flowing from Prime Minister Narendra Modi's visionary leadership, the National Health Policy 2017 was formulated to achieve the highest possible level of good health and well-being, and universal access to good quality healthcare services without anyone having to face financial hardship as a consequence. A step towards fulfilling the vision of the National Health Policy 2017, Ayushman Bharat is a pioneering initiative to adopt a continuum of holistic approach to healthcare, comprising two principal pillars.

First is the creation of 1.5 lakh health and wellness centers, which will bring healthcare closer to the homes of people. The second pillar is Pradhan Mantri Jan Arogya Yojana (PMJAY) which will provide health protection cover to poor and vulnerable families. Ayushman Bharat will be implemented at an unprecedented scale to bring about a paradigm shift in healthcare.

The launch of PMJAY within the next few days will be historic as it will ensure access to healthcare to more than 10 crore poor and vulnerable families in India who have hitherto been left out of the healthcare system and the development story of the country. As the largest targeted health assurance scheme in the world it presents the opportunity, and together with it the challenge, of providing secondary and tertiary medical care to over 50 crore poor and deprived Indians – a population almost equal to that of Europe or the combined population of US, Canada and Mexico. Beneficiaries under PMJAY will be entitled to a medical cover of up to Rs 5 lakh per family per year.

Through entitlement under this scheme the poor will now no longer have to struggle with the financial trouble of illness, can avoid falling into moneylenders' trap, and save their families from dire impoverishment. According to the most recent national survey, around 5 crore people in India are pushed below the poverty line due to high out-of-pocket health expenditures.

Disease is deeply debilitative with the potential to handicap a person's abilities to provide for himself and his family, pushing the whole family into crushing poverty. Considering this, PMJAY has taken up a holistic approach covering secondary and tertiary medical care (including pre- and post-hospitalization) to help the poor realize their dreams of receiving quality medical care. The scheme will strive to remove the mental and economic burden of paying for the medical treatment by reducing catastrophic expenses and to create a cashless and paperless process for receiving treatment.

PMJAY will revolutionize healthcare in many ways. First, it marks a significant movement towards the government's promise of sabka saath sabka vikas, of taking every Indian along. Second, it brings to the fore health as the focus of our policy agenda, making it one of the flagship initiatives of the BJP-led government.

Third, it will bring together a whole range of stakeholders and pave the way for opening new hospitals, clinics and diagnostic labs in tier II and III towns. An enhanced network of hospitals will spur demand for a large number of jobs for doctors, nurses and other staff in the near future. PMJAY will be disruptive as it will expand the supply side by improving access to private as well as public healthcare services.

Fourth, the initiative will also lead to the creation of a whole cadre of certified frontline health service professionals called Pradhan Mantri Aarogya Mitras (PMAMs) across the country. The PMAMs will be the primary point of facilitation for the beneficiaries to avail treatment at the hospital and, thus, act as a support system to streamline health service delivery. In addition, MoU has been signed with Common Service Centers (CSCs) for beneficiary identification, with over 3 lakh service centers for identifying beneficiaries.

Finally, PMJAY has the potential to become one of the best examples of cooperative federalism in the democratic world. Its successful implementation will be based on a solid partnership between the Centre and states. So far, 26 states have signed MoUs with the Centre and more are expected to come on board. PMJAY will also exemplify smooth functioning and consolidation of different technology tools, for Indian healthcare to take its great leap forward.

Source

Back

World's largest healthcare scheme Ayushman Bharat will cover 500 million people: Health Minister J P Nadda - Financial Express – 16th September 2018

What is touted as the world's largest healthcare scheme – Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY) – will benefit over 500 million (50 crore) people which is more than the combined population of the United States, Canada and Mexico, Union Health Minister Jagat Prakash Nadda said.

The scheme, to be launched by Prime Minister Narendra Modi on September 25, will provide a cover of up to Rs 5 lakh per family per year for secondary and tertiary care hospitalization.

"This is a very bold decision taken by Prime Minister Modi and this will ensure that poor people will not have to bother any longer for the cost of healthcare facilities," Nadda told IANS in an interview here.

He said that 30 states and union territories had signed the memorandum of understanding and have started working on implementation of the mission. Maharashtra and Tamil Nadu have also joined the scheme recently. A pilot project of the scheme was launched in 22 states and union territories.

The ministry has received 15,686 applications for hospital empanelment, including private hospitals, so far.

"Majority of the people (who will now be covered under the Ayushman Bharat scheme) could not afford the healthcare and hospitalisation. Things will change for a big population of the country," Nadda, whose ministry has been preparing for the launch of the ambitious healthcare scheme, said.

"Over 10.74 crore vulnerable entitled families (approximately 50 crore beneficiaries) will be eligible for these benefits. PMJAY will help reduce catastrophic expenditure for hospitalisation, which impoverishes people and will help mitigate the financial risk arising out of catastrophic health episodes. When fully implemented, PMJAY will become the world's largest fully government-financed health protection scheme," Nadda said.

As per the health ministry estimates, 62.58 per cent of the population in the country has to pay for their own health and hospitalization expenses and are not covered through any form of health protection. Each year 4.6 per cent of the population is pushed below the poverty line as people meet their healthcare needs spending large proportion of their income and savings, borrowing money or selling their assets.

Ayushman Bharat aims to cover prevention, promotion and ambulatory care at primary, secondary and tertiary level.

The scheme envisages creation of 1,50,000 health and wellness centres which will bring health care closer to the homes of the people. These centres will provide comprehensive primary health care covering both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services.

The second component of the scheme is the PMJAY which provides health protection cover to poor and vulnerable families for secondary and tertiary care. The National Sample Survey Organization (NSSO) has found that 85.9 per cent of rural households and 82 per cent of urban households have no access to healthcare insurance/assurance.

More than 17 per cent of Indian population spends at least 10 per cent of household budget for health services.The PMJAY primarily targets the poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data for both rural and urban areas.

Source

"There is no cap on family size and age as well as restriction on pre-existing conditions (to avail the new scheme). It will cover hospitalisation cost from inpatient care to post-hospitalisation care. Everything will be cashless and paperless," Nadda said.

Back

Crop Insurance

Insurance companies to pay 12% interest to farmers in case of delay in settlement claims – Financial express – 18th September 2018

Insurance companies will have to pay farmers 12 per cent interest in case of delay in settlement of claims under the farm insurance scheme PMFBY, as per the new guidelines of the government. "Government has decided to incorporate the provision of penalties for states and insurance companies for the delay in settlement of insurance claims under the Pradhan Mantri Fasal Bima Yojana (PMFBY)," an official statement said.

This provision is part of the new operational guidelines issued by the government for the implementation of the PMFBY. "The farmers will be paid 12 per cent interest by insurance companies for the delay in settlement claims beyond two months of prescribed cut-off date. State governments will have to pay 12 per cent interest for the delay in release of state share of subsidy beyond three months of prescribed cut-off date submission of requisition by insurance companies," the statement said.

The PMFBY, launched in 2016, is the most important tool to insure agriculture against climate and other risks. The scheme which is an improvement over the previous agriculture insurance schemes not only provides subsidised insurance to the loanee farmers but also avails it to the non-loanee farmers.

The new operational guidelines, which come at the onset of the rabi season, which starts from October, also detail a Standard Operating Procedure for evaluation of insurance firms and remove them from the scheme if found ineffective in providing services.

The government has also decided to include perennial horticultural crops under the ambit of PMFBY on a pilot basis. The scheme provides add on coverage for crop loss due to attack of wild animals, which will be implemented on a pilot basis. Aadhaar number will be mandatorily captured to avoid duplication of beneficiaries.

In order to ensure that more non-loanee farmers are insured under the scheme, the insurance companies are given a target of enrolling 10 per cent more non-loanee farmers than the previous corresponding season.The new guidelines address the current challenges faced while implementing the scheme by putting forth effective solutions. "The much-demanded rationalization of premium release process has been incorporated in the new guidelines…This will reduce the delay in settling the claims of farmers," the statement said.

Source

Back

Motor Insurance

Mandatory third party insurance for vehicles to benefit consumers, insurers: Experts - The Economic Times – 16th September 2018

Even as customers buying cars and two-wheelers post September 1 need to shell out more as premium with Irdai making long-term third party insurance mandatory, industry and experts feel it will ultimately benefit consumers besides the insurers.

It addresses the issue of under-insurance and inculcate a sense of compliance among those who otherwise evade the law by not buying the third party motor insurance after the initial year of vehicle purchase, said an analyst.

Following an order from the Supreme Court, the Insurance Regulatory and Development Authority of India (Irdai) has directed the insurance companies to offer three-year third party insurance cover for new cars and five-year such policy for new two-wheelers from September 1, 2018. The new guideline will contribute to higher premium income for the companies selling motor insurance. However, chinks remain as customers will be bound to make long term premium without the freedom of choice to make a switch from one insurer to another, said an industry official on the condition of anonymity.

"Introduction of mandatory long term policies for new vehicles will go a long way in addressing the problem of under-insurance of motor vehicles. As is well known, motor insurance penetration drops to around 40 per cent for two-wheelers and 60 per cent for four-wheelers within 2-3 years of vehicle purchase.

"For us at ICICI Lombard, it is a matter of deep concern that so many vehicles are being deployed on the roads without an adequate motor insurance cover....We are sure that motor insurance will rise further in coming years," said Sanjeev Mantri, Executive Director - ICICI Lombard General Insurance. He said with the long-term policy in place, this problem should be largely addressed.

With this ruling, there will be higher number of motor insurance compliant vehicles as against the current levels running on the roads and that too for a longer time, said Devendra Rane, Founder and Chief Technology Officer of online insurance selling portal Coverfox.com. "While these long-term policies will definitely bring down the lapsation ratio of all the insurers in the motor insurance segment, the customers will also be benefited from this move as they would be insured for a longer period of time and would be free from the yearly exercise of policy renewals," Rane said.

Though the customers will feel the initial pinch as they would be paying higher premiums right at the start, they can find solace in the fact that they would be free from yearly premium increases, he added. An analyst with a brokerage firm said companies will definitely benefit from the higher income from premium even as customers may feel the pain of paying an upfront payment, it will eventually help them in a long run.

"The number of road accidents are highest in India globally as many vehicle owners deliberately do not buy third party motor insurance after a period and expose others at risk on the road. So, this will help address that challenge," said the analyst.

By this, the government is actually stressing more on the awareness part of third party motor insurance by making it mandatory for a longer period, so that people actually start realising that this is an important part. And by this people, may go for longer term comprehensive policy as well, the analyst added. On the flip side of the new rule that may affect customers adversely, Coverfox.com's Rane says one can also see it as a whip in the hands of vehicle dealers to force buyers into accepting insurance plans at much higher cost from them only rather than what would be available in the open market.

The new guidelines might be used by dealers and showroom owners into misguiding the customers or enticing fear in their minds. "They might try to convince the vehicles buyers into believing that if they buy a new vehicle without an insurance from them, they would be falling on the wrong side of the law and face legal fines and penalties," Rane said.

According to a calculation by Coverfox.com, vehicle owners of large capacity engine would see a drastic increase in their premium outgo. Cars of engine capacity higher than 1,500 cc will see more than 3-fold rise in their premium at Rs 24,305; engine capacity between 1,000 cc to 1,500 cc will see rise of 3.3-times at Rs 9,534 while those with engine capacity less than 1,000 cc will see their premium rise by 2.86-times to 5,286.

For two-wheelers, vehicles between 150 cc-350 cc and higher than 350 cc will witness 5.54 times and 5.61 times jump in premium payout at Rs 5,453 and Rs 13,034, respectively. Two wheelers with engine capacity not exceeding 75 cc will result in premium rise by 2.45-fold to Rs 1,045 and for 75 cc-150cc, it will be up by 4.56 times to Rs 3,285.

When these higher third-party premiums are added to the comprehensive plans, the total premium outflow will have a northbound jump, Rane said. This will impact the planned budget of consumers as also they are forced to

buy insurance from dealers at the time of vehicle purchase at a cost higher than the price through some other channel, said Animesh Das, Head of Product Strategy at Acko General Insurance.

Source

"Consumers who had dilemma of purchasing new vehicle may take a call to avoid buying the vehicle or may end up purchasing a lower variant, so for an average car the increase in on-road is going to be in range of 10 per cent or more," Das said.

Back

Pension

National Pension System: PFRDA caps equity mutual funds investment by NPS – Financial Express – 19th September 2018

In order to prevent pension fund managers from investing a large sum of money in equity mutual funds, Pension Fund Regulatory and Development Authority (PFRDA) has put a cap on equity mutual fund investment at 5% of the total corpus. The pension fund regulator has issued a circular last week which outlines the change in investment guidelines for National Pension System (NPS) regarding investment in equity mutual funds by pension funds.

"It has been decided by the authority to put a limit of 5% on investment in equity mutual funds in a manner that the aggregate portfolio invested in such mutual funds shall not be in excess of 5% of the total portfolio of the fund at any point in time and the fresh investment in such mutual funds shall not be in excess of 5% of the fresh accretions invested in a year," says the PFRDA's circular.

Equity investment norms

The regulator has decided that the amount of investment in any mutual fund mentioned in any of the categories or exchange traded funds or index funds made by pension funds through professional fund/asset managers shall be excluded for the purpose of computing their investment management fee.

While investing in mutual funds or index funds or exchange funds, the underlying scrips will have to comply with certain norms. The shares of the companies should have market capitalization of not less than Rs 5,000 crore as on the date of the investment and derivatives of the underlying shares should trade in either of the two exchanges. The investment guidelines will be applicable to all NPS schemes —central and state governments, private sector, NPS Lite and Atal Pension Yojana.

Save on fund management charges

The investment guidelines of PFRDA dated June 3, 2015 and May 4, 2017 mention that if the pension fund has engaged services of professional fund/asset managers for management of its assets, payment should be made on the basis of the value of the funds invested. Experts say the PFRDA's circular bring in clarity and will save investors from paying double incidence of cost; first as investment fee charged by pension fund manager and second, the expense fees to be paid to mutual fund companies.

Experts also say that pension fund managers levy an investment fee of 0.01% of the investment corpus. As a result they are not able to do active fund management and rely on mutual funds. After the circular, pension fund managers will now have to develop in-house asset managers to manage the investment corpus. At present, NPS has a total of eight pension fund managers.

Higher equity investment in NPS

Private sector subscribers of NPS can now invest up to 75% in equity under the active choice option. It is an option where the subscriber decides his asset mix. It was fixed at 50% since NPS was opend to private sector subscribers in 2009. Higher equity exposure will benefit young investors with a long working life as equity tends to give higher returns over a longer period of investment.

One can even opt for the life cycle fund where the equity exposure come down as one grows older. The pension fund regulator had introduced two more life cycle funds apart from the existing moderate life cycle fund (with 50% equity cap) for private sector investors in auto choice. The two were: Aggressive life cycle fund (LC 75) with 75% equity cap and the other, conservative life cycle fund (LC 25) with cap on equity at 25%.

As investing for pension is typically for 30 to 35 years, it makes sense to invest in equity for higher returns. The G N Bajpai committee report on review of investment guidelines for NPS submitted worked out a simulation model

which shows rejigging of portfolio from 10% equity plus 50% government debt plus 40% corporate debt to 50% equity plus 25% each for corporate and government debt will increase the pension wealth by 46% after three decades.

Source

The regulator's decision to cap equity investment through mutual funds at 5% will help investors to save on costs, especially younger investors who would prefer a higher equity exposure.

Back

PFRDA and IRDAI working to streamline issuance of annuities - The Hindu Business Line – 18th September 2018

The pension and insurance regulators are finalizing a strategy to streamline the process for payouts under the National Pension System, including online purchase of annuities, easier KYC norms and a simplified form.

"Purchase of annuity is mandatory under the NPS. We are working on an online system where, once a person retires, he or she can place an online request with the NPS for buying an annuity and this can be forwarded to the annuity service provider of choice," said Hemant Contractor, Chairman, Pension Fund Regulator and Development Authority (PFRDA).

Sources said officials from the Insurance Regulatory and Development Authority of India (IRDAI) and PFRDA, along with executives of insurance companies, which work as annuity service providers to the NPS, met last week to discuss the proposal as well as address the problem of delay and suggest possible solutions.

Delayed annuities

While Contractor did not comment on the number of annuities that are delayed, sources said about 6,000 to 7,000 annuities are yet to be issued. "The delay in issuance of annuities was just one of the issues discussed at the meeting. There are only a few such cases," said Contractor.

Sources said that the process for issuance of annuity will now start at least three months in advance to ensure that all details, including address, phone number and bank account details, are up to date.

NSDL, the central record-keeping agency for the NPS, will be roped in for this. "The problem is that often the subscriber on retirement moves to his village or ancestral place, making it difficult to trace him or her," noted the source.

The regulators have also come to an agreement to use the know-your customer (KYC) done by the IRDAI for the payout, rather than by both. Further, a new form will also be issued to the customer to fill in details.

Under the NPS, at the time of exit from the scheme, a subscriber has to purchase an annuity from an empaneled annuity provider, which gives a regular pension. At present, there are five empaneled annuity service providers — Life Insurance Corporation of India, HDFC Standard Life Insurance, ICICI Prudential Life Insurance, SBI Life Insurance and Star Union Daichi Life Insurance.

Source

Back

PFRDA caps equity mutual fund investment at 5% of total corpus – Mint – 17th September 2018

The pension fund regulator has put restrictions on the amount of money an asset manager can invest in equity mutual funds, taking cognizance of the fact that some of them had invested huge sums of money in these investment vehicles.

The Pension Fund Regulatory and Development Authority (PFRDA), in a 20 August circular, has capped investment in equity mutual funds at 5% of the total corpus. The rule will also apply to fresh investments. After permitting active management of the equity portfolio in 2015, the regulator also allowed pension fund managers to invest through mutual funds to offer them flexibility.

"We wanted to provide flexibility and an avenue for the fund managers to park the money while waiting for the right scrips," said B.S. Bhandari, whole-time member (economics), PFRDA. "However, some fund managers chose mutual funds as their investment strategy and invested huge sums of money. Being fund managers themselves, it's incorrect to outsource fund management," he added. Mint had flagged this issue last year.

Of the eight pension fund managers that NPS (National Pension System) has, this move will primarily impact Kotak Mahindra Pension Fund Ltd (KMPFL) because it had invested its entire equity portfolio through mutual

funds. According to the company, it has about Rs 225 crore of assets under management under the equity portfolio.

"We have diluted about 50% of our mutual fund holding, but some mutual funds have an exit load, so we will wait for the exit load period to get over before redeeming the rest in the interest of the investors," said Sandeep Shrikhande, chief executive officer, Kotak Pension Fund.

The fund manager is now moving to invest directly in equities. While this strategy tantamount to outsourcing fund management, it also means that investors pay extra costs of the mutual funds.

"Our focus has been to give superlative returns to the investors, and since asset management companies have the required skill set and capabilities we chose mutual-funds investments. Despite the costs, we were able to beat returns of other fund managers," added Shrikhande.

LIC Pension Fund Ltd had also invested a portion of its equity funds through mutual funds. LIC Pension Fund didn't respond to a query seeking comment. According to the annual report for FY18 of LIC Pension Fund, it had about 11% of its equity corpus invested in mutual funds for the private sector and about 13% for the government sector.

As on 31 August, the fund manager had assets under management of around Rs 455.79 crore in the equity portfolio of the private sector NPS. Its exposure to mutual funds has come down to less than 4%, according to portfolio disclosure of 31 August.

Source

According to a chief investment officer of a pension fund company who didn't want to be named, this circular will also impact some state-run pension fund managers as they had invested in Bharat 22 exchange-traded fund (ETF).

Back

Interview

People feel the need for term covers to protect lifestyles: Pankaj Razdan, Aditya Birla Sun Life Insurance - The Economic Times – 17th September 2018

Customers are increasingly looking at pure risk term policies on the back of rising disposable incomes and growing awareness about insurance, Pankaj Razdan MD & CEO, Aditya Birla Sun Life Insurance and Deputy CEO, Aditya Birla Capital tells *ET Wealth*.

How have customer preferences evolved? Are you seeing an increase in demand for protection policies?
The middle class lifestyle has changed and there is a need to protect that lifestyle. There is more awareness. This was not the case 10 years ago when the principal use of a life insurance policy was to save for say a child's wedding. People were satisfied with a money back policy that offered a lump sum after 20 years.

Our consumption levels have increased – everyone wants to own a house at a younger age, an overseas holiday and a certain lifestyle that cannot change overnight if the breadwinner dies. So, what are the options available to protect this lifestyle? Nothing but a pure protection policy.

Today, it is more relevant than before. Savings-oriented products are good too, but one cannot leave out the most important part—protection, the core objective of life insurance. Moreover, all stakeholders are working in tandem to create a sense of purpose around buying insurance. Low penetration means the potential for scaling up is high.

How have regulations helped?
After 2010, Ulips became cheaper and transparent, and the industry started doing well. When you make something good for customers, it's going to yield positive results. For the industry, customer has become king and protection has become big.

What kind of changes in product regulations do you hope for?
More flexibility would help. The products should be easily acceptable, more outcome-oriented, rather than drawing a tight boundary and saying that you can do this and not do this. Today, our design approach is predictable—if you compare 29 products, they will be very similar. Overall broad guidelines and internal flexibilities can lead to more innovations that ultimately benefit customers.

What has been the impact of long-term capital gains tax on Ulips?
I wouldn't say it is a big benefit for us or big draw down for mutual funds. There was talk for a few days, but at the end of the day these are two different industries. I don't think the industry has used it as an instrument to get more money. Tax rules can come and go but that cannot be the basis for deciding where you will invest. Your goals should be the basis. For us, the big focus is protection. We ask our agents not to come back without informing customers about protection policies as otherwise you would be doing injustice.

Many life insurance companies, including yours, are launching critical ailment covers. Why should customers choose them over indemnity-based covers?
Term insurance can take care of the family if the breadwinner dies, but what if someone is alive but is unable to draw income? Diseases also eat into savings. That is the idea behind promoting these products. Ours are long-term products unlike critical illness policies from non-life insurers. You don't have to keep worrying every year. You can buy a policy with a tenure of 5-10 years. Slowly, people have started warming up to the idea.

But why disease-specific covers?
A critical illness policy covers around 20 ailments, most which you will not contract. But two to three are killer diseases. Our research shows heart, cancer and renal diseases are the major killers. So we decided to price them separately.

The regulator wants products to be simpler. How are you doing that?
We have created an architecture where all products are simple. Our objective is to make sure that everyone – you, me, and the person on the street, understand the products. For example, in our cancer product, we say if you are diagnosed with stage 1 cancer, take 30% of the sum assured. At stage 2 or 4, you are entitled to say 70%. Nobody has to remember too many things. We are also not restricting products to geographies or income levels. When you do that the product design gets complicated.

What about riders? Has the awareness increased?
Unfortunately, people have not used riders in a big way.

What steps have you taken to check mis-selling?
The industry has done a good job over the last few years. The trust has come back. Mis-selling is a function of a number of things. How do you recruit distributors? How do you measure their performance? Purely on the basis of sales logged or how much profit they bring in? We measure the relationship quotient at each branch. We rate them on the basis of sales they make and mis-selling recorded. Compensation is based on quality, not just quantity. Technology throws up which product is suitable for you. When you do all these things, mis-selling will not happen.

How do you measure satisfaction?
An external agency's study shows we have moved from rank 12 to three this year on customer loyalty. Our Net Promoter Score (NPS) has improved three times. More people are recommending us. Around three and a half years back, our 13th month persistency was in the late 50s. Now it's at 75%. During the same period last year it was at 71%. So every year, persistency is increasing, more people are coming back to us.

Source

Back

More states will join Ayushman Bharat after its success: Nadda - Hindustan Times – 17th September 2018

The Centre is confident of getting more states to join its ambitious healthcare scheme, Ayushman Bharat, after they witness the success of the programme, Union health minister JP Nadda has said.

The Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana, which will be launched by Prime Minister Narendra Modi on September 23, aims to provide healthcare cover of up to Rs 5 lakh per family per year to 500 million poor people.

"It's a Rs 5-lakh cover for 55 crore people. The whole scenario will change because of the numbers that will come to get treated… Tamil Nadu signed, Karnataka is coming on board… Kerala is still dealing with the floods. Punjab is going to come, Telangana is on board," Nadda said in an interview. Nadda said he made repeated appeals to Delhi and Odisha to join. "They know their minds best, but I will appeal to them time again and again," said the union health minister when asked if they were resisting because of upcoming elections. Ayushman Bharat is touted as the world's largest public-funded health insurance programme.

Some of the states not ruled by the BJP have expressed reluctance over the scheme. Odisha said it had its own healthcare scheme and did not need to launch Ayushman Bharat. Nadda said the scheme was "a major step towards" towards universal health cover. "When universal screening begins, it becomes universal health coverage. We are on track," he said.

Prime Minister Narendra Modi will launch the Ayushman Bharat scheme on September 23 in Ranchi, followed by the nationwide launch of his government's flagship health insurance programme that aims to provide Rs 5 lakh hospitalisation cover to up to 107.4 million poor and vulnerable families. How prepared is India for the rollout? Union health minister JP Nadda tells why he is confident about the programme being on track, and how the remaining challenges will be overcome.

How ready are the states for the Ayushman Bharat launch on September 23?
We've come a long way since the scheme was announced in the Union Budget on February 1. In February itself, we held consultations with states to discuss their concerns, how they wanted to get involved, their level of involvement, what they wanted from this scheme, et cetera. We next had consultations with stakeholders and the DGHS (director general of health services) office was asked to identify secondary and tertiary care procedures (offered free under Ayushman Bharat). In March, we got the approval of the cabinet very fast.

Is it the fastest approval for a health programme in India?
Yes, we got it on March 20. We next established the National Health Agency (NHA) and asked for state health agencies to be formed. By June, 19 states came on board and we started working jointly.

The programme gives health insurance coverage to 107.4 million families and more than 550 million people. As it will be digital, paperless and cashless, we have got the best in the field of IT on board. There are three financing models — insurance model, trust model and hybrid model— and 19 states have chosen a trust model.

What is the level of preparation in the states?
The letters with individual QR codes are being printed and will start getting distributed. Around 10,000 'Arogya Mitras' from empaneled hospitals are being trained by the National Skill Development Corporation to act as an interface between patients and hospitals. Individual beneficiaries will take letters with QR codes to an Arogya Mitra at the hospital to get a card with the names of all the family members. Around 80% of the identification process in rural areas and 70% in urban areas are complete. This week, ANMs (auxiliary nurse midwife, a village-level health worker) will start distributing the letters.

Doctors can prescribe 1,350 procedures and packages and, after a patient is admitted, treated and feedback taken, the payment will be done within 15 days of the patient being discharged.

Do the beneficiaries fully understand the benefits?
Things are still unfolding. Only when the letters reach the beneficiaries will they understand and react. The common service centres — around 300,000 are being set up — will tell every individual whether they are on the list or not, and then people will go to Arogya Mitras. That's when the discussions will start.

What about approval for medical emergencies?
In a medical emergency, you can get pre-approval for procedures. If the approval doesn't come in half an hour, it is deemed to be approved.

How will you prevent and detect fraud?
There are 94 types of automatic checks in the digital system that will set off alarms if it detects aberrant data. There will be social audits. We will also learn as we go forward.

What about data privacy?
Data security of international standards has been maintained. We did not have SOPs (standard operating procedures) for it in India, so we have adopted international SOPs as our own. This is the first time such data security systems are being used in India.

Are you saying my data with the Ayushman Bharat system will be safer than with a corporate private hospital?
Private hospitals follow security, but they don't have standardized data protection procedures.

How many hospitals have applied for empanelment?
We have more than 10,000 applications. It's not enough to treat 107.4 million families...

No, but it's a start. The IMA (Indian Medical Association) has signed an MoU — it is on board. Other hospitals will come on board.

Why are you so confident?
It's a Rs 5 lakh cover for 55 crore people! The whole scenario will change because of the numbers that will come to get treated. Today (September 11) Tamil Nadu signed, Karnataka is coming on board the day after tomorrow (September 13). Kerala is still dealing with the floods. Punjab is going to come, Telangana is on board.

Are Delhi and Odisha resisting because of upcoming state elections?
They know their minds best, but I will appeal to them time and again (to come on board). Today (September 11) I appealed to Delhi again. People should get the benefits. I also said this to Naveen Patnaik ji.

Tamil Nadu has a scheme where higher grade hospitals have higher packages.

We also have gradation — a hospital and a nursing home can't have the same payment system. As services improve, the packages go up accordingly. Ayushman Bharat is applicable for district hospitals and above. It is for lifesaving procedures in hospitals with the capacity to do it.

What about primary healthcare, screening and referrals?
We have projected to have 150,000 health and wellness centres by 2020. There is a road map. At this point, 2,500-plus are ready, and by the end of the year, we will cross 10,000. Next year, we'll add 40,000 and keep scaling it up. The reason why it is 10,000 to 15,000 initially is because manpower is being trained. Once we have trained staff and more trainers, we will scale up.

What is the expected budget after a full rollout?
It's an open-ended budget. I'm reiterating that the Prime Minister's priority is to see change on the ground. I'll give you one example. The PM came up with a programme called Pradhan Mantri Dialysis Yojana. Where was the budget? But in the first year, Rs 900 crore was provided for it. In the same way, the National Health Agency (NHA) will get the money because the payments have to be done within 15 days. We have to give penalty if the payment is delayed beyond 15 days.

How much will the penalty be?
It will be according to the rates. The NHA will decide, but all payments have to be made within 15 days, so budget is no issue.

Does this mean India's public health spending will increase next year?
It will increase after this. You see, when health coverage expands so much, it will automatically go up.

By how much do you expect it to go up next year?
As needed. The way it works is, we write to the finance department and we get it. The finance minister has openly said that whatever you need for it, you'll be getting it.

How often does the PM take review meetings? What does he discuss?
Every week. All details, all presentations are discussed — how will it be rolled out, what are the systems being used.

What is the biggest challenge?
We need to strengthen IT to roll out a programme on such a big scale.

Why do several beneficiaries still do not know about Ayushman Bharat.

That is going to happen only when they get letters, not before that.

What is the delay?
The data has to be absolutely correct. People spell their names in different ways. Prakash may be spelt 'Parkash' or 'Prakash'. Balvinder may be spelt 'Balvindra'. We have to get the right person, and IT has to catch that and use that QR code to also include the family members.

How will the eight EAG (empowered action group) states with the weakest health infrastructure and human resources meet supply demand gaps?
They are working very hard. Once you have the common man with Rs 5 lakh support for treatment, hospitals will come up. And with hospitals, doctors will come.

The changes will happen in tier-two and tier-three cities, where more hospitals will open.

Doctors, who work in large hospitals, will become mobile and visit different hospitals in other towns on different dates and days. They will visit, operate, and come back.

There is portability. Where there are no hospitals, people will go to other places for surgeries, like they are doing today.

But today they don't have money; tomorrow they will have money.

And when the money stays in hospitals, they will use it to consolidate and develop infrastructure and capacity.

How will you ensure there is an uninterrupted supply of drugs?
The free drugs and diagnostics supply chain is being made more robust. We are using IT-enabled systems to monitor medicines stocks in community health centres (CHC), primary health centres (PHC) and sub-centres to ensure stocks don't run out. Under free drugs and diagnostics, around 50 types of drugs and five tests are being done at PHCs, more than 100 drugs are available at CHCs, and more than 600 drugs at district hospitals. It will all be digitally managed. The Centre has assisted states with more than Rs 16,000 crore over four years for drugs and diagnostics.

How will patients' grievances be redressed?
Complaints can be made online and offline to the state health agency and within 15 days, they need to submit the report.

Is Ayushman Bharat a step towards universal health cover?
It is a major step towards it.

On the one hand, it takes care of the secondary and tertiary health of the poor, vulnerable and marginalized, and on the other, it offers universal health screening of cervix cancer, breast cancer, oral cancer, hypertension, diabetes, tuberculosis and diabetes. Then we have free drugs and diagnostic facilities for all. When universal screening begins, it becomes universal health coverage. We are on track.

Source

Back

Opinion

Home insurance scheme on lines of Ayushman Bharat, PMSBY needed to mitigate damage from natural catastrophe – Financial Express – 19th September 2018

Nature is the greatest gift that mankind is bestowed with and yet can also act as an infinite destroyer. This has been seen in the recent Kerala floods, causing destruction at a scale not seen since 1924. The insurance sector globally is on the frontline of the battle against climate change as extreme weather events become more frequent and severe. Insurers are investing in analytics, satellite and drone-based surveying, flood areas imaging and other useful technologies to deal with unprecedented Nat-Cat (natural catastrophe) events.

Low insurance penetration
During natural calamities, a drastic difference has been noted between the incurred economic losses and the insured losses. It is not surprising that general insurance penetration in India stands at barely 0.9%, even when the industry is more than a century old. It is estimated that the economic losses from property damage worldwide, occurring due to natural calamities in the last 10 years, was $1.3 trillion—and of this, as much as 70% remained uninsured and over 80% in India.

This is seen in home insurance penetration where, despite the fact that most Indians spend their life savings to buy their home, less than 1% of homes in India are insured. Even in urban households, awareness of home insurance is less than 40%. Insurers have observed a notable spike in the number of enquiries immediately after a natural catastrophic event, but gradually they fade.

Impact on economy
Natural disasters put a significant financial burden on governments too, especially as the devastation caused by disasters remain primarily uninsured. In recent years, severe disasters impacting government finances include Cyclone Hud Hud in 2014: Rs 70,000 crore economic losses, of which only Rs 4,000 crore was insured and Chennai floods in 2015: Over Rs 15,000 crore economic losses of which only Rs 5,000 crore was insured.

It is therefore critical for the government to look at an alternative financing and risk transfer mechanism as insurance would provide quick liquidity and pay-outs during natural disasters.

Mass insurance schemes

The government has launched a few mass insurance schemes such as Ayushman Bharat for health insurance, PMSBY for personal accident insurance, PMFBY for crop insurance, etc. Such initiatives protecting the citizens against various eventualities go a long way. Similarly, a home insurance scheme in association with insurance companies can be implemented that would cover losses to property due to catastrophic events. An index-based policy can be announced which will compensate for the damage caused by a natural disaster where the triggers of a Nat-Cat event will be predefined. The premium of the same can be collected while taking property tax and once the claim is triggered, it can be directly transferred to beneficiary's Jan Dhan Account linked to the home insurance policy.

Recent events have been a reminder to how immense the impact of natural catastrophes can be, both socially and economically and the urgent need for bringing in a basic security net and bridging the insurance coverage gap in the country. The need is for the government, the insurance industry and the regulator to come together to provide a basic catastrophe cover, as a major natural disaster can wipe away the entire lifetime savings of an individual and make the road to financial recovery extremely difficult.

Source

Back

Why most people still do not feel the need to buy insurance - Financial Express – 17th September 2018

Penetration, density and growth rate are the three vital parameters to judge the performance of the insurance industry. Penetration is the ratio of total premium collected by all the insurers in a financial year to the GDP of the country.

In this respect we have been struggling at 2.5-3.5% in spite of the liberalization of the insurance industry 18 years ago and 24 life and 33 non-life insurance companies in India. In 2016-17, insurance penetration was a mere 3.49%. The global insurance penetration ratio is 6.3%, with China at 4.2% and the UK at 10.2%.

Insurance density is per capita insurance premium. While global insurance density was $638 in 2016, for India it was $59.7 in 2016-17. The share of non-life has been a mere $13.2 for the same period. Insurance density of China was $337 in the same year.

Higher growth has no meaning

We, in India, revel in the fact that the growth rate in the insurance industry is always higher than the growth rate of GDP. The life insurance industry registered 11% year-on-year growth for new business premium for 2017-18 generating revenue of Rs 1,94,000 crore. Similarly, gross direct premium of non-life insurance has been Rs 1,51,000 crore for 2017-18. During the last six years, non-life premium grew at a much higher rate of CAGR 16.65%, spurred by health insurance.

The market share of private life insurers is 29%; however, in non-life the private sector achieved 48% market share.

An incisive study of the growth of the insurance industry would point to a highly mediocre performance with a very insignificant impact of the opening of the sector to global players. Whatever new happened to the industry following the entry of well-known Indian and global brands is confined to adoption of customer facing technology and selling through a few new channels, mostly dominated by bancassurance. But very low density as well as insurance penetration indicates that nothing significant has actually happened.

Products not helping much

There are, of course, exceptionally good performances by a few companies compared to their peers but as an industry the sector has failed the citizens. The data on number of claimants and claims settled by both life, non-life sectors in Kerala after the recent floods would confirm my views. I am sure the number of death claims settled would be far fewer than the number of people losing their life in the unprecedented floods. Similarly, the amount paid as claim settlement for loss of property is also likely to be far less than the value of property and wealth destroyed. The practice by successive governments in states and Centre to announce ex-gratia relief to the affected people or to the dependents of the deceased has also taken away the shine from the insurance industry.

In fact, for all such disasters the only scientific method of indemnifying the loss is insurance. Its continuous usurping by politicians has made the industry complacent. In such a scenario people too don't feel obliged to buy an insurance policy either for themselves or for their property.

The pent-up need for insurance by the people can be met by radical, strategic and structural shifts. Growth which does not improve penetration and density should not satisfy the insurers. Data analytics must be adopted to harness the potentiality available by way of demographic dividend. The conventional underwriting practices must be replaced by digital tools to make customers happy.

Retention of customers, conservation of business and repeat sales to meet all the insurance needs may multiply the business manifold. The CSR spends by companies must earmark large sum for creating insurance awareness. The size of the Indian insurance market is likely to grow to $280 billion by 2020. This may not be enough when we consider even minimum insurance needs of the 45% of our population which is dependent on 50% of people in the earning age group and the growing industrialization of our country.

Source

(The writer, Kamalji Sahay is former MD & CEO, Star Union Dai-ichi)

Back

Decoding return of mortality charge in Ulips - Financial Chronicle – 17th September 2018

Unit linked insurance plans (Ulips) have been actively around in the market since last 10-15 years and have evolved considerably keeping the changing demands and needs of investors. While traditional Ulips had earned a bad reputation for being overly priced, the new-age online Ulips are quite popular, with some of the new offerings boasting of zero premium allocation and lower policy administration costs. A Ulip is a product offered by insurance companies that, unlike a pure insurance policy, gives investors both insurance and investment under a single integrated plan.

Apart from being cost-efficient, allowing free switching between funds and tax-benefits, you can also find a unique offering in the new-age Ulips such as return of mortality charge to make investments in it more lucrative than ever.

Mortality Charges: When an investor buys a life insurance plan, the premium paid includes many charges like agent's commission, policy administration charges and mortality charges. Of these, mortality charges are charged towards providing the insurance cover to the insured; it is the actual cost of the insurance cover. In Ulips too, mortality charges are charged to investors by canceling units at the prevailing net asset value throughout the term of the policy.

These charges are calculated based on the amount of cover sought, age, health, gender, and other factors that influence the span of life of an individual. In case of Ulips, the charge is dependent on the sum at risk (sum assured minus the fund value). It is deducted along with the other charges in the policy.

It is important to note here that the new-age online Ulips do not include any agent commission. What new-age Ulips offer: While mortality charges are the true cost of the insurance cover, this amount is not paid back to the insured if he survives the term of the insurance.

However, Bajaj Allianz Life disrupted the online Ulip space by offering return of mortality charge, thereby making their online Ulip equivalent to a pure investment plan. Through in Ulips feature, Bajaj Allianz Life-Goal Assure ensures that at the end of the policy term, the mortality charge deducted throughout the tenure of the policy, both in regular and top-up premiums if any, is added back to the regular premium fund value and top-up fund value.

Industry is now catching up on this innovation and a similar feature is now available in Canara HSBC Oriental Bank of Commerce Life Insurance-Invest 4G plan. In simple words, the mortality charges deducted are returned to you.

Other benefits: Apart from the return of mortality charge benefit, the new-age online Ulips also offer the following benefits:

Exempt-exempt-exempt (EEE) benefit: The EEE benefit has made the investment in Ulips a lucrative option. The triple tax exemption available during investments, earning and withdrawal stage ensures that customer is getting a value preposition.

The budget 2018 introduced the long-term capital gain tax (LTCG) on mutual funds, making investment in Ulips an attractive option over mutual funds.

Multiple switching options: Ulips allow investors to switch between different investment options to match with their financial goals. For example, a 25-year old investor might want to expose a bigger part of his portfolio to equity and eventually bring the allocation more in favour of debt as he ages. This can be easily achieved through Ulips without any interruption in capital earnings. On the other hand, in mutual funds, you have to pay certain taxes while redeeming your units and switching to another scheme.

Goal-based investing: Ulips have the potential of helping you create wealth over a long period of time. This makes them a good investment option for your financial goals like retirement planning, purchasing a house, covering wedding expenses, or create a corpus for your children's higher education needs. Since Ulips come with a minimum lock-in period of 5 years, they also help you inculcate the habit of saving and investing and reaching your goals in a more focused manner.

The fourth generation Ulips are highly cost-effective and incur negligible charges due to the insurance regulatory and development authority of India (Irdai) putting a cap on various charges applied on Ulips. The fund management charge (FMC) is now around 1.35 per cent and most new-age Ulips offer zero premium allocation charge and policy administration costs. This is a huge change from the second and third generation Ulips after 2010 and 2015, respectively.

The new-age online Ulips are making the benefits of a bundled investment cum insurance package available to investors with attractive features. If you purchase Ulips online, then you can save on the distribution and commission costs that are applied when an investor purchases through an agency or a bank. Add to it the return of mortality charge and fund management charge capped at around 1.35 per cent, and you have a highly cost-effective investment option.

The new-age online Ulips have learned from the mistakes done by their previous generations and offer a goal-based, tax-efficient, and cost-effective investment option.

Source

(The author is associate director and cluster head- life insurance, Policybazaar.com)

Back

Non-disclosure of ailments can lead to trouble – Mint – 17th September 2018

Some months ago, a middle-aged gentleman was recommended cataract surgery. He applied for a cashless claim to his health insurer. The family floater health insurance had been running for five years with no claims. The insurer when assessing the claim found, from the doctor's notes, that the patient had been suffering from sleep apnea over the past seven years and this fact had not been declared when the insurance was first bought five years ago. They rejected the claim and cancelled the entire family's insurance on grounds of medical non-disclosure.

Non-disclosure of a pre-existing medical condition is one of the top three reasons for claim rejection. Such cases throw up several questions on health insurance principles. The first is why does non-disclosure take place? In most situations, medical non-disclosure is deliberate, with the insurance buyer and sales person mutually deciding to hold back information. Their worry, not unfounded, is that if one's health condition is transparently shared, then the insurer will not provide insurance. In my own insurance buys, I have been guilty of nudging the nurses to add an extra inch or cut a few kilos so that my BMI comes squarely in the acceptable range. However, such behavior simplistically assumes that insurers will not find out undisclosed information. The buyer significantly underestimates the insurer's strong finding-out capability. When claims are filed many years after buying the insurance, customers always forget what they had disclosed in the proposal forms but insurers never do. They are able to access meticulously recorded diagnoses sheets and internal hospital case reports and get the correct facts fairly quickly. This is why, in addition to the obvious point that one should tell the truth, buyers should give accurate information and make sure this is properly recorded in the proposal form. When in doubt, disclose.

Insurers can help by making their catch-all medical questions in the proposal form more specific. These are the questions that insurers ask so that you declare anything material that they may not have asked you already. Some of these catch-all questions encourage non-disclosure because they are so broad in their scope. For example, commonly posed questions are if you have "been under any regular medication (self/prescribed)" or

"undergone any hospitalisation/illness/surgery." The answer to this is always going to be "yes", which means that more detailed questions will follow. That is why buyers will expediently say "no", resulting in possible non-disclosure that they may rue many years later when making a claim. A few insurers are using more specific questions such as whether you are "currently suffering from any symptom(s) or complaint(s) persisting for more than five consecutive days". These are more easily answered.

For a moment, let us assume that the insurance buyer has sinned and hidden a medical issue. Should that always be grounds for rejecting a claim or cancelling the insurance? I think not. The insurer must ask what they would have done had they got that information earlier? If they would have issued the insurance then the claim must be paid but if the non-disclosure would have been grounds for rejecting the proposal then the insurer is right in rejecting the claim now. The problem is that these rules are not transparent and, at the time of a claim, insurers are most likely to argue that the non-disclosure was material. It would be useful for the industry to list down, in proposal forms or correspondence, the principles that explain better what medical conditions are considered material.

An important consideration should also be the number of years after buying an insurance that a claim is made. In life insurance, the law specifies that claims cannot be rejected after three years. We need a similar provision in health insurance. The timelines can be longer since the gestation between having a chronic condition and resulting hospitalisation is longer.

Let's now advance the assumption by saying that there was non-disclosure that was material and resulted in an early claim. Even in such situations, the insurer should not unconditionally cancel the insurance, if other family members are part of the plan. Why should they be left uncovered because one person in the family hid information? I have seen cases where such summary cancellation has taken place. In one case, a spouse's claim was rejected on the grounds that the primary insured had hidden information. A more nuanced approach is required where only the person who hid material information is penalized.

Finally, if the circumstances are such that health insurance must be cancelled, there is the matter of premiums paid. Effectively, what the cancellation implies is that the policyholder was never really insured even though they paid premiums. Insurers should think about a fair penalty for such situations. Forfeiting the entire premium paid may be high and, perhaps, a partial refund could be made.

Returning to the case that I started out with. The insurer initially terminated the entire family's insurance but, through a process of grievance redressal, finally agreed to continue the family's insurance but not the persons who hid information. That was a good decision.

Source

(The author, Kapil Mehta is co-founder, SecureNow Insurance Broker Pvt. Ltd)

Back

IRDAI Circular

Source

Gross direct premium underwritten for and upto the month of August, 2018 is available on IRDAI website.

Back

Global News

Cyber premiums in Asia may reach $1bn by 2025 – Asia Insurance Review

The cyber insurance market in Asia could potentially grow to reach $1bn in premiums by 2025, according to Delta Insurance Managing Director Ian Pollard.

Speaking at the 3rd Asia Cyber Summit in Singapore yesterday organized by Asia Insurance Review, Delta Insurance – a Cyber and Technology Lloyd's Cover holder in Asia – said now is the best time for corporates to buy cyber cover as rates are bound to harden as insurance companies acquire more data around cyber risk.

Mr Pollard estimates that less than 5% of businesses in Asia hold specific cyber insurance policies, compared to 14% in Australia and 10% in New Zealand respectively. He added that data breaches are set to become more common, noting that half of Delta's cyber claims currently relate to malware.

In terms of evolving threats, he highlighted the dramatic rise of 'crypto jacking', which is the practice of hijacking computers to mine cryptocurrency. Crypto jacking saw an 85-fold increase in 4Q17 which coincided with the spike in bitcoin prices.

Risk management

Commenting on the modern risk landscape today, Guy Carpenter's Managing Director, Head Casualty Specialty Practice (Asia-Pac), Thomas Herde, said that companies are currently covered for only 15% of potential cyber-risk losses, against 59% for property, plant and machinery losses.

Given the worth of intangible assets today compared to traditional physical assets, companies ought to do more to protect themselves against 'intangible risks' such as reputational risk, he said.

From a risk management perspective, he also noted how insurance companies should be aware of the prospect of overlapping cyber liabilities from the traditional classes they underwrite.

In the absence of a special clause it is often extremely difficult to determine first, whether all losses have arisen from one event or cause, and secondly, precisely what that event or cause is. Therefore for cyber, the only sensible way of resolving the difficulty is by having recourse to an aggregate reinsurance structure which does away with the necessity of looking for a single common underlying event or cause.

"It is prudent to have an overarching cover in case specific event covers don't work," said Mr Herde.

Source

The conference, sponsored by Singapore Re, Horangi and Singapore College of Insurance, ends today.

Back

China: Improvement in motor profitability seen as limited – Asia Insurance Review

Improvement in profitability for motor insurance in China will be limited until there is significant industry consolidation, says Moody's Investors Service in reports released last week. Motor insurance products are increasingly becoming a commodity business, so Moody's expects smaller insurers to be further disadvantaged and marginalized as price takers in the industry.

As for large insurers, Mr. Edwin Liu, a Moody's associate analyst, said, "The five listed traditional Chinese P&C insurers reported weaker profitability, which testifies to continued challenges in their predominant motor business." The listed P&C insurers reported total premium growth of 15% in the first six months of 2018 from a year ago, powered by a 38% surge in non-motor premiums, which more than offset weak growth of only 6% in motor premiums.

Moody's expects this divergence to continue because the insurers remain focused on developing non-motor insurance, in particular liability and agriculture insurance, which enjoy better underwriting profitability than motor insurance. The weakness in motor premiums also reflects lackluster new vehicle sales and competitive pressure from further pricing liberalization.

The listed P&C insurers reported an average combined ratio of 98.0% in the first half of 2018, a deterioration from 97.5% a year ago, mainly driven by an increased loss ratio because of lower premium adequacy amid intensified motor insurance pricing reform.

Life insurers

Commenting on listed life insurers, Mr. Liu said, "The six listed Chinese life insurers reported lower new business in their first half results, but their credit standing was supported by healthy growth in their in-force books and strong capitalization." For the listed life insurers, aggregate first-year premiums fell by 24% from the same period last year mainly because of regulatory restrictions on sales of short term saving products and increased competition from other wealth management products.

The insurers also reported an average 9% growth (not annualized) in their embedded value (EV) compared with year-end 2017, despite a sharp decrease in the value of new business (VNB) mainly driven by volume decrease. Looking ahead, Moody's expects a recovery in new policy sales to reflect falling yields on wealth management products and greater efforts by insurers to market protection-type products. Total premium will grow on renewal premiums from their in-force book. Renewal premiums now account for over 60% of total premiums for most insurers, and are a more stable source of cash inflow than single premiums.

Source

Australia: Regulator releases standards for private health insurance industry – Asia Insurance Review

The Australian Prudential Regulation Authority (APRA) has released a package of prudential standards and guides aimed at improving governance and decision-making in the private health insurance (PHI) industry.

Following an extensive period of industry consultation, APRA confirmed last week it had finalized three new prudential standards, along with two prudential guides designed to assist insurers fulfil the requirements of the standards.

The measures, outlined in a consultation package released in February this year, introduce stronger prudential standards that have successfully lifted capabilities across other APRA-regulated industries.

The new prudential standards for PHI:

- comprise a stronger cross-industry standard on board governance and renewal;
- require boards to establish and apply a written policy to ensure the competence and integrity of anyone exercising material influence over the company; and
- require PHIs to appoint an auditor to provide independent advice on their operations, financial position and risk controls.

APRA has also released two Prudential Practice Guides to help PHIs meet the requirements of the new standards.

APRA Executive Board Member Geoff Summerhayes said the new measures would bolster insurers' resilience as the industry confronted mounting sustainability challenges.

"As affordability declines and the proportion of Australians covered by private health insurance falls, especially among the young, it's vital that boards and management can swiftly identify emerging issues and respond decisively.

"These new measures are designed to encourage timely and effective decision-making, helping insurers remain sustainable, and minimizing the risk of failures that could threaten policyholders' cover," said Mr. Summerhayes.

The revised prudential standards will come into effect from 1 July 2019.

The announcement is the culmination of Phase Two of APRA's roadmap for reviewing the PHI prudential framework. Phase One, focused on risk, resulted in April's adoption of a cross-industry risk management prudential standard. Phase Three – capital – will commence later this year.

APRA is the prudential regulator of the financial services industry. It oversees banks, credit unions, building societies, general insurance and reinsurance companies, life insurance, private health insurers, friendly societies, and most members of the superannuation industry.

Source

Back