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QUOTE OF THE WEEK

"The path from dreams to success does exist. May you have the vision to find it, the courage to get on to it, and the perseverance to follow it."

Kalpana Chawla

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Expense Loading

Definition: Expense loading is the amount included in the premium charged by an insurance company to cover its administrative and maintenance costs.

Description: In order to cover for their operating expenses, the insurance companies include this as a portion of the total premium payable. Expense load is an addition to the pure premium accommodates for overhead expenditure of the insurance provider.

Source

INSURANCE INDUSTRY

Lessons for Indian Insurance Industry from Other Matured Economies – IndiaCSR – 23rd October 2019

For people who purchase different types of insurance, finding out that following up on it is a tedious process can be quite disheartening. Insurance providers have been accused of taking years to settle claims.

For insurance companies, this may mean losing out on valuable customers due to the nature of the competition. There are numerous hindrances and faulty decisions, starting from making people to buy insurance online and providing support. The hindrances make insurance companies lose out on potential long-term customers.

While some insurance companies dealing with various types of insurance around have introduced several changes to the way they work, thanks to the ever-emerging tech and big data, there are still several that lack behind and the link between them is widening up. Such a big gap in a competitive market is worrisome for the market players.

Insurers spent nearly $187.3 billion on IT in 2016, which accounted for around 25% of the whole financial spending. According to a survey by McKinsey, a global consulting firm, nine out of ten insurance companies came up with a conclusion that traditional legacy software and infrastructure were barriers in the digitisation process.

Understanding Data to Improvise on Existing Standards

For existing players in the industry, it is crucial that they look at the existing stands in the insurance market from around the world and learn from the conclusive results.

The seventh annual report laid out by the Federal Insurance Office (FIO) of the United States Department of the Treasury marked the United States as the world's largest single-country insurance market in 2017 with different types of life insurance, accounting for a 28% market share of global direct premiums. With a market as big as that, several business practices have led to conclusive results that current Indian insurance companies can pick cues from.

Some of the main problems that the US insurance market currently needs to address revolve around three factors:

- The complicated internal process of insurance companies.
- The insured not being satisfied with their service providers.
- Young minds not quite eager to join the insurance sector.

These are some serious equations that the insurance industry as a whole needs to address with several types of insurance. According to a recent study by Morgan Stanley and BCG, about 60% of insurance clients around the world weren't satisfied with their service providers whereas nearly 50of insurance clients thought of turning to newer models.

The tool of machine learning and automation

What takes time is paperwork — manual notifications, following up, arranging schedules, and such takes a lot of time. Moving to software that promotes automation and picks up on the repetitive nature of tasks in the insurance workflow can save valuable time and reduce the cost spent on the routing workflow.

For example, Fukoku Mutual Fund Insurance replaced 34 employees by AI and now looks forward to boosting productivity by 30 per cent, saving $1.25 million alone in the very first year.

With different types of life insurance, Machine Learning and Artificial Intelligence also reduce the risk of human error, thus reducing the time it takes for people to claim their insurance. Companies are also using AI to come up with innovative means to help ease up the process of claiming insurance. Agro insurance companies in the United States are using satellite images that help with the low-cost and efficient assessment of agricultural loss claims.

For dental insurance, companies are using state-of-the-art technology — companies like Bean are using smart toothbrushes to track how well their customers take care of their teeth.

Based on the data gathered by the smart toothbrush, the company comes up with personalised insurance plans and claims to offer up to 25 per cent lower rates compared to its competitors in the market.

Every year, insurance agents spend thousands of tedious orders, chatting with the clients to resolve basic to complex queries. This time can otherwise bye harvesting by employing chat bots that work on automated responses. They are integrated into the website as well as social networks such as Facebook and Twitter to help people buy insurance online.

Ontario-based Excalibur Insurance has made use of AI bots to automate their interactions with clients. They are available throughout the clock on their website or Facebook. The system engages new clients, works with claim reports as well as service requests. Here, renewal notifications and features such as assigning tasks to specific agents can help a great deal.

Features such as live chat and online service support with different types of life insurance can help services communicate better with their clients. Future Generali has been an insurance rider for people to buy insurance online in this segment by providing several channels of communications to its customers.

With a wide range of insurance options Future Generali is opening new doorways to the way insurance is looked at by people, protecting and ensuring things that people tend to cherish so much in their lives.

(The writer is Rusen Kumar.)

TOP

Source

INSURANCE REGULATION

Make sure insurance ads are clear, fair and not misleading: Irdai to insurers – Mint – 20th October 2019

Regulator Irdai has asked insurers to ensure that advertisements of insurance products are clear and do not convey a fabricated sense of security to prospective customers. The Insurance Regulatory and Development Authority of India (Irdai) in a circular on 'insurance advertisements' has prescribed dos and don'ts for insurance companies to comply with.

All insurance advertisements should ensure that "communications are clear, fair and not misleading whatever is the mode of communication", it said.

They should use material and design (including paper size, colour, font type and font size, tone and volume) to present the information legibly and in an accessible manner, Irdai said. Also, the mandatory disclosures should be in the same language as that of the whole advertisement. "Names of insurance products or benefits" must not use terms or phrases that convey a fabricated sense of security, the circular said.

It further said that in case of communications through internet, an "insurer should ensure that the recipients/viewers have the opportunity to view the full text of the relevant key features; terms and conditions; any other applicable risk information...they shall not be hidden away in the body of the text". Irdai said the success of insurance sales communication depends on public confidence and the faith they repose in the insurers, when they receive a communication from companies promoting their products.

"As it may be difficult for the public to understand and evaluate the inherent details in the various insurance products, it is of paramount importance that the publicity material is relevant, fair and in simple language enabling informed decision making about whether or not to buy a specific insurance product," it said. The circular also said all licensed entities soliciting insurance business should mention their identity and contact details. Any person found to be guilty of misleading the prospect on any insurance product will be liable for regulatory actions, it added.

TOP

Source

LIFE INSURANCE

Surrendering your life insurance? Think again – Financial Express – 23rd October 2019

While the insurance regulator has taken steps to increase the persistency ratio of life insurance policies, customers should check the ratio before buying a life cover. Higher persistency ratio of an insurance company means that policyholders are satisfied with the insurer's policies and renewing their policies every year.

In 2017-18, the persistency ratio for India's life insurance industry stood at 69% in the 13th month. It means that out of 100 policy holders, only 69 renewed their life policies after the first year. The 61st month persistency ratio was only 35%, which means nearly two-thirds of all policyholders did not renew their policies after the fifth year. Poor persistency levels or higher lapsation means people are paying huge surrender costs.

Customers' trust

Persistency ratio of all life insurance companies is measured at 13th month, 25th month, 37th month and 61st month and the data is available in Irdai's Handbook of Indian Insurance Statistics. As a life insurance policy is to secure long-term financial commitments, lower long-persistency means that policyholders are not giving adequate thoughts to the needs of a life insurance policy. It is calculated on the basis of the number of policyholders paying the premium divided by net active policyholders, multiplied by 100.

In 2017-18, the highest 61-month persistency (based on number of policies) was recorded by ICICI Prudential Life Insurance Company at 49%, followed by Kotak Mahindra Life Insurance Company at 47.2%. The lowest 61-month persistency was recorded by DHFL Pramerica at 15.6%, followed by Shriram Life Insurance at 19.24%. The highest 13-month persistency was recorded by Kotak Mahindra Life Insurance at 81.11%, followed by ICICI Prudential Life Insurance at 80.7%. The lowest 13-month persistency was recorded by Shriram Life Insurance at 52.02%, followed by Bharti AXA Life Insurance at 57.44%.

Long-term needs

Buying an insurance cover is protecting one's family in the long run. When a policy lapses because the policyholder does not pay to renew the policy, then the policyholder loses money through surrender charges. Continuity in life insurance would enable a policyholder to reap the benefits of the policy as according to the Insurance Laws Amendment Act, all commitments will be honoured if a policy has been active for three years without any breaks.

As a thumb rule, an individual should have a life insurance cover that is 10 times his current annual income. Experts say that the total sum assured of all life policies put together must adequately cover one's dependents in the long run, should something happen to the breadwinner.

Surrender value

In July this year, the insurance regulator had revised the surrender charges for both linked and non-linked life insurance products. All protection-oriented non-linked products will have guaranteed surrender value. If the premium has been paid for two consecutive years, the policy will acquire a guaranteed surrender value. It will be 30% of the total premium paid less any survival benefits already paid, if surrendered during the second year of the policy.

In case the policy is surrendered during third year, it will be 35% of the total premium paid, less any survival benefits. If surrendered between the fourth and the seventh year, then it will be 50% of the total premium paid. In case it is surrendered during the last two years of the policy, then the policyholder will get back 90% of the premium paid.

Before the new norms came in from July, if a policyholder had a traditional plan, which bundles investment with insurance, he would lose all his money if it was not renewed in the second year. If one surrendered after year two and three, the insurer paid back only 30% of the total premium. Between year fourth and the seventh year, the surrender value was 50% of the premium paid. After eighth year, the surrender value increased.

Before purchasing the policy, it is important to understand whether the policy suits the needs of the customer. Read the fine-print, so that if there is any issue it can be address during the free-look period. This will increase the chances of the policyholder sticking to the policy in the long run.

(The writer is Saikat Neogi.)

Source

TOP

Traditional insurance plans need to look at Ulips for cost structure – Mint – 23rd October 2019

How would you react if you were told that you could lose your money if you exited a product before its term expired or that if you stuck on, the returns may be nothing to write home about? This straight talk, in all likelihood, will prevent many from buying traditional insurance-cum-investment plans. But, in reality, the agents' smooth talk and smart product packaging get many to line up for them—these bundled plans are sold as guaranteed products, with an element of insurance and tax benefits. Lack of proper disclosures makes matters worse. On top of all that, these plans come with heavy surrender penalties that can eat up the entire investment in the first year. The two areas of costs and disclosures are crying for attention. Here are the details.

Product construct

These are opaque plans that can broadly be classified as participating and non-participating plans. Participating plans guarantee a certain minimum amount, typically the sum assured, and promise periodic additions, which are pegged to the performance of the underlying fund (also known as par fund) and that, once declared, are guaranteed. In the case of non-participating plans, the returns are guaranteed, and the benefits are declared upfront.

Surrender value in a Ulip vs a traditional savings plan

Traditional bundled plans are opaque products which do not disclose costs. However, the embedded costs are exorbitant that come home to bite very hard during a surrender. Comparatively, the costs in Ulips are capped and surrender charges are much lower. Here is how the costs in Ulips and traditional plans stack up and what a policyholder would get if she plans to surrender after a year. Since this is for illustrative purposes only, it assumes a zero growth rate in the fund value

Ulip		Traditional plan
₹1 lakh	Premium invested	₹1 lakh
₹12,500	Premium allocation charge capped at 12.5%	Not disclosed
₹1,181	Fund management charge capped at 1.35%	Not disclosed
₹6,000	Policy administration charge capped at ₹500 per month (₹6,000 a year)	Not disclosed
₹2,832	Mortality cost for a 30-year-old male for 15 years and ₹10 lakh sum assured	Not disclosed
₹6,000	Surrender charge applicable in the first year capped at ₹6,000	100%
₹71,487	Your corpus	Nil
71%	Percentage of principal corpus you get back	Nil

Keep in mind that a Ulip comes with a lock-in of five years to discourage early surrenders. Hence, when you surrender, you will only get the money after the lock-in period is over; The insurance cost is for a 30-year-old male, for a 15-year term and for a sum assured of ₹10 lakh; Ulips can charge lower than the maximum allowed, but for illustration purposes we have taken the maximum limit; Cost of insurance is based on the benefit illustration given by the insurer

Source: Mint research

As investment products, their USP is the fact that they come with an added layer of insurance, but so far these products have not impressed financial planners due to poor returns. "These plans enjoy superior

tax treatment compared to a normal fixed deposit due to the insurance wrapper. Despite this, the returns are not very competitive," said Shyam Sunder, managing director and co-founder, PeakAlpha Investment Services Pvt. Ltd.

Returns from participating plans are in the range of 4-6%, according to experts, while the many non-participating or guaranteed plans that Mint's personal finance team has decoded in the past give returns of around 4%.

(The writer is Deepti Bhaskaran.)

TOP

Source

New rules in place for Ulips, other life insurance products: Know the impact – Financial Express – 22nd October 2019

The Insurance Regulatory and Development Authority of India (IRDAI) on July 8, 2019, has brought in significant changes to regulations related to non-linked life insurance products and unit-linked life insurance products (ULIPs). Designed to make life insurance more favourable to customers, the new rules offer substantial benefits and flexibility to policy-holders. In terms of the revival of policies; minimum guarantee on surrender, partial withdrawals from unit-linked pension policies and life cover, among others these rules certainly make it easier for the policyholders.

Let's look at six major modifications to the rules by IRDAI and its impact on the policy-holders.

1. Increasing the revival period for a lapsed policy:
Old rule: Presently, a lapsed policy can be revived within a period of two years from the date of lapsation by paying arrears of premium with interest and fulfillment of medical requirements, if any.

New rule: The revival period has been increased to three years in case of unit-linked life insurance plans and five years in case of non-linked products from the date of first unpaid premium. A policy lapses or becomes paid-up with reduced benefits when a policyholder fails to pay a premium on time.

Impact: For insurance customers who may find themselves facing a lapsed policy, the new norm offers a bigger window of opportunity to revive the policy during the revival period. Additionally, the move will help insurers spruce up renewal premiums and retain good customers.

2. Partial withdrawal in ULIP pension plans:
Old rule: IRDAI regulations allow for partial withdrawal in ULIP plans. However, partial withdrawal from pension products was kept out of the ambit.

New rule: The regulator has now allowed for withdrawal of up to 25% of the fund value from pension ULIP policies. The withdrawal is allowed only after completing the mandatory lock-in period of five years and is permitted for specified purposes such as higher education and marriage of children or treatment of self or spouse or for the purpose of buying or constructing a residential house. Besides, a policy-holder can withdraw the amount three times during the entire term of the policy.

Moreover, IRDAI has raised the lump sum withdrawal limit on maturity of pension plans to 60% from the existing 33%. In other words, the policyholder can commute up to 60% of the pension fund and utilize the balance amount to purchase an immediate annuity or deferred annuity from the same insurer at the then prevailing annuity rate. Significantly, the policyholder has been given an option to purchase the available annuity from any other insurer using a proportion of the amount available to buy an annuity.

This is very much like the provision under the National Pension System (NPS) wherein the 60% withdrawal is tax-exempted.

Impact: Allowing for premature withdrawal of part of pension funds for critical milestones in life gives policy-holders the much- needed flexibility in deploying funds in case of liquidity crunch for such events. Moreover, bringing the withdrawal limit at par with NPS, gives the ULIP pension products a competitive edge and makes it much more attractive to potential customers.

3. Lower life cover in ULIPS:
Old rule: Based on the age of the policy-holder, insurers were mandated to offer a minimum cover of 10 times the annual premium to those under 45 and seven times to those over 45.

New rule: The new regulations have discarded the differential minimum life cover based on age. Now the life insurance company has to offer a minimum seven times of life cover for regular premium paying polices and 125% life cover of the premium in case of single premium policy.

Impact: Under the income tax norms, maturity proceeds from a ULIP policy was exempted from taxation provided that the sum assured was at least 10 times the annualized premium. Now that the minimum sum assured has been brought down to 7 times the annual premium, the policyholder will most likely have to pay tax on maturity amount unless the tax laws change appropriately. This may not augur well with customers as well as insurers because ULIPs are popular as tax-saving tool.

4. Guaranteed surrender value for non-linked products:
Old rule: The surrender value, which is the amount received for discontinuing the policy, was based on premium paying terms of the policy.

New rule: Now a policyholder can acquire a surrender value after payment of at least 2 consecutive years premiums. He/she will be entitled to a minimum guaranteed surrender value which shall be 30%of the premiums paid (less survival benefits already paid) if the policy is surrendered during the second year. They will get 35% if surrendered in third year; 50%, if surrendered between 4th and 7th Policy year and 90% if surrendered during the last two policy years.

Impact: The regulation partially streamlines and makes it a less costly affair for a policyholder to exit traditional or outdated non-linked products.

5. High-risk products with short tenure in protection products:
Old rule: So far, IRDAI did not allow insurance companies to bring out products with tenures of less than five years.

New rule: The insurance regulator has now allowed insurers to introduce pure risk non-linked products with terms as small as one month.

Impact: Will widen customer-base for insurance sector by attracting individuals with short term insurance needs. The move also allows insurance companies to bring out innovative products like episodic insurance.

6. Premium reduction in ULIPs:
Old rule: IRDA had no provisions to reduce the premium earlier.

New rule: A policyholder now has the option to reduce the premium in ULIPs by up to 50 percent of the original premium, only after 5 years of the policy are complete. However, this option can be availed only if allowed under the product and once the premium is reduced it cannot be increased again in the future.

Impact: While the option to reduce the premium will come in handy for those who may face liquidity crunch, the death benefits and sum assured under the policy among other terms may be revised with change in the amount of premium.

Conclusion

The new guidelines by IRDAI will help pull in more customers towards insurance. Besides, the regulations are likely to give insurance companies the much-needed impetus to launch a new variety of products, which will further boost and deepen the insurance market.

(The writer is Rakesh Wadhwa.)

TOP

Source

This Diwali, gift insurance to your family - The Hindu Business Line – 21st October 2019

Instead of buying material things like a new house or a car, this Diwali, why not try and secure the future of your loved ones.

The diya of life may extinguish any time. While you can't do anything about your physical absence, you can at the least secure the family's financial future by buying a life insurance policy.

A life insurance cover can make up for the loss of income when you are not there, take care of children's education, pay outstanding liabilities and give your spouse financial security.

Basics

A term insurance plan is pure-risk cover and has no-frills attached. At the end of the term of the policy, if the policyholder survives, no benefit gets paid. But in case of his unfortunate death during the tenure of the policy, the nominee gets the insurance cover amount also called sum assured (SA).

The premium even for a large SA of say Rs. 1 crore is very nominal today in a term insurance policy.

For a male of 30 years (assuming he is a non-smoker), the annual premium for an SA of Rs. 1 crore for cover till 70 years of age would be Rs. 9,000-12,000. For a female of the same age, the premium works out to Rs. 7,000-9,000 per annum.

Buy term insurance as early as possible because as you grow older premiums increase (once you buy the policy, the premium remains fixed all through the term). Also, it does become more difficult to get insurance if you develop chronic diseases such as diabetes.

When taking a life insurance policy is sure not to fall for the bundled products which are nothing but savings/investment plans and has a high cost structure. Traditional endowment plans may at best give you 4-5 per cent return (IRR). In ULIPs (unit linked insurance plans), as investment is made in market products, risks are high and returns are not guaranteed. ULIPs may be an investment option for investors with high-risk appetite, but it falls short as insurance.

Further, make up your mind on the following before you set to choose the insurance company – the sum assured, the term of the policy, premium payment period – whether limited term or regular (till end of the policy) and premium payment mode.

There is a thumb rule that can help you decide on the cover amount for life insurance. This is generally 10 times the annual income of the individual. Say suppose you are earning Rs. 15 lakh a year, you need a life insurance policy of SA of at least Rs. 1.5 crore. But depending on your liabilities and the lifestyle of the family, you can even look for higher SA. To decide on the term of the policy, you need to first think about how long you will have an active work life and will be supporting the family financially. If you think that by 60 years you will retire and you will have no financial liability, you can choose to have a cover till 60 years. This will help reduce premium on the policy. But note that today many insurers including LIC, SBI Life, ICICI Prudential and HDFC Life give cover till 70/75 years or some even till 80 years. If you had a

late career start and late marriage and kids and think your financial responsibility will go beyond 60/65 years, you can have extended term coverage.

The decision on the premium payment term is also important. Insurance companies offer two options – one, limited period premium payment where you pay premium only for 5/7/10 years (while cover is for the whole period you choose), and two – regular premium payment where you pay premium till end of the policy.

In limited premium payment while the premium outgo annually will be higher, you will end up paying lower premium all together for the cover. Take for instance, you are a 30-year-old male (non-smoker) and want a cover till 70 years for Rs. 1 crore. If you pay annual premium of Rs. 10,600 on this policy for the next 40 years, you would have ended up paying a total premium of Rs. 4.24 lakh. However, if you had opted to pay premium for 10 years in total, your annual premium would be Rs. 23,577 and you have ended up paying a total premium of Rs. 2.35 lakh – a saving of Rs. 1.89 lakh. Thus, if you can manage to pay higher premium, go for a limited premium payment term. Also, paying premium annually is a better thing to do, rather than going in for a quarterly/half-yearly option, if you can afford it. When you pay quarterly or half-yearly, total premium that is charged is higher.

How to buy?

Insurance is cheaper when bought online as there is no agent commission involved. Akin to shopping on Amazon, today, buying insurance on respective insurer's website or on the site of insurance aggregators like policybazaar.com is very simple, it can be done in 10 minutes. If you fill in details of your age and the term you need to be covered and SA you are looking for, it will calculate your premium. If you are okay with it, you can proceed by providing KYC details and filling in the disclaimer form on health. After this, you will proceed to make the premium payment, and in next few minutes, you will have bought the policy.

When selecting a life insurer, pay attention to the claim settlement ratio – this indicates how good the insurer is in settling the claims of the policyholders. LIC, the insurance behemoth, and Max Life Insurance have the highest claim settlement record of 98 per cent and 98.3 per cent respectively. This means, they settle 98 of every 100 claims they receive. Others such as ICICI Prudential Life (97.9 per cent) and HDFC Life (97.8 per cent) too have a good record.

Secure the life of your spouse

There is a risk of your lenders claiming to be beneficiaries of your insurance policy when there is an outstanding liability. When lenders approach the court to take their dues form the insurance settlement, there are high chances that they may get a verdict in their favour. To avoid a situation like this, register the life insurance policy under the Married Women's Property (MWP) Act. When you buy a life insurance policy under the MWP Act, the wife and/or children will be the only ones who will have access to the claim amount. However, note that life insurance policies can be brought under the MWP Act only at the time of purchase; it can't be done later.

(The writer is Rajalakshmi Nirmal.)

TOP

Source

Now, know how your insurance agent is being paid for policy sold to you – The Economic Times – 21st October 2019

High commissions, rewards and opaque structures have meant traditional insurance-cumin

Vestments have often been mis sold by intermediaries. The promised rewards are an incentive to sell products that earn high commissions and don't necessarily fit the policyholders' needs. "These rewards are paid over and above commissions for targets achieved. These could be in the form of sponsored holidays, household appliances or even apparel," explains financial planner Pankaj Math pal, Founder, Optima Money Managers.

So far, life insurers showed commissions and such rewards separately. That is set to change. “These rewards were usually disclosed as part of overall operating expenses. Now, they will have to be disclosed under the commission’s schedule. The purpose is to bring about uniformity in disclosures,” says Raman deep Singh Sahani, CFO, Bajaj Allianz Life.

Individual product category	Max remuneration/ commission**	
	First year	Renewal
SINGLE PREMIUM		
Life products except pure risk products	2%	NA
Pure risk products	7.5%	NA
Immediate/deferred annuity	2%	NA
REGULAR PREMIUM		
Pure risk	40%	10%
Deferred annuity/ pension	7.5%	2%
OTHER POLICIES*		
5 years	15%	7.5%
6 years	18%	7.5%
7 years	21%	7.5%
8 years	24%	7.5%
9 years	27%	7.5%
10 years	30%	7.5%
11 years	33%	7.5%
12 years and above	35%	7.5%

Note: *Years represent premium paying terms. ** As percentage of premium. Rewards, paid over and above commissions, are capped at 20% of commission. Source: Irdai

The new rulebook

Now, the Insurance Regulatory and Development Authority of India (Irdai) has directed insurers to show such rewards and remuneration paid to agents, brokers or other intermediaries under the head ‘Commission’ in their financial statements. The objective is to ensure consistency, uniformity and fair presentation. “Rewards and/or remuneration to agents, brokers or other intermediaries shall be shown as part of head ‘Commission’ in the financial statements.

Towards more transparency

Rewards shall be shown as a separate line item in Schedule 2 ‘Commission’, below Net Commission in the financial statements,” the insurance regulator decreed recently. Irdai allows insurers to pay rewards of up to 20% of first year commissions to distributors whose revenue from non-insurance intermediary businesses does not exceed 50% of their total revenue in a year. The idea is to reward agents who primarily rely on their agency business for their livelihood, and not institutional distributors like banks.

While insurers have always been required to disclose rewards, the new rule will make it easier for policyholders to understand the payout structure. “A lay person might not understand the nitty-gritties of financial statements and disclosures. Now, total payouts, including commissions and rewards, made to intermediaries can be seen under a single schedule,” says Anil kumar Singh, Actuarial Officer, Aditya Birla Sun life Insurance. It will be simpler now to compute the percentage of payouts.

Do remember, however, that Irdai’s move will not impact your returns in any way. “These are related to disclosures and will not impact the product’s internal rate of return for policyholders,” says Sahani.

This is similar to Sebi’s rules for disclosure of remuneration paid by asset management companies to their mutual fund distributors. The market regulator’s definition of commission encompasses direct monetary payments as well as payments made in the form of gifts/rewards, trips and event sponsorships. “Rewards to insurance intermediaries are covered by Irdai Compensation to intermediaries’ regulations (2018). Nature and quantum of such rewards are closely related to commissions and hence disclosing the same under the head Commission is more natural,” says Man deep Mehta, EVP and Deputy CFO, Max Life Insurance.

The transparency in disclosure will help policyholders evaluate an agent’s recommendation in the context of incentives the latter is entitled to. “It is important for the policyholder to know the total amount the agent is likely to earn by selling the policy in a single section,” says Math pal. However, he points out that clarity on the quantum of rewards could tempt some policyholders into demanding ‘pass-back’, a malpractice that entails the agent passing on a part of his commission to the former. “Policyholders, on their part, should refrain from asking for the rebate and focus on ascertaining whether the product suits their needs or not,” he adds.

EoM disclosures

Irdai has also sought to bring about uniformity in disclosures of expenses of management (EoM) incurred by insurers.

EoM represents the total expenses incurred by insurers including administration, operating and commission-related expenses, among other things. "Some insurers are presenting the operating expenses in the Revenue Account (policyholder's account), net of the excess EoM beyond allowable limits. This does not present the exact expense overrun position of the insurers," Irdai stated, while laying out rules for presentation of these expenses.

Put simply, some insurers charge expenses that are beyond the permissible limits to the shareholder's account. Now, they will have to first charge the same to the policyholder's account. "The equivalent amount is to be then transferred from the shareholder's account to policyholder's account," says Singh. This must have been a demand from investors and analysts to understand the total expenses companies were incurring towards sales and administration say industry watchers.

While it is largely a step to standardise accounting practices and does not affect returns, greater transparency is in the interest of policyholders and investors. "The circular is a welcome step towards standardizing reporting of expenses by insurers. This is an enhancement of disclosures which will not impact financial results of insurers. Improved disclosure will let a policyholder know how much of the deficit towards EOM has been funded through shareholder account," says Mehta.

(The writer Preeti Kulkarni.)

TOP

Source

New rule on market conduct does little to curb insurance mis-selling – Mint – 21st October 2019

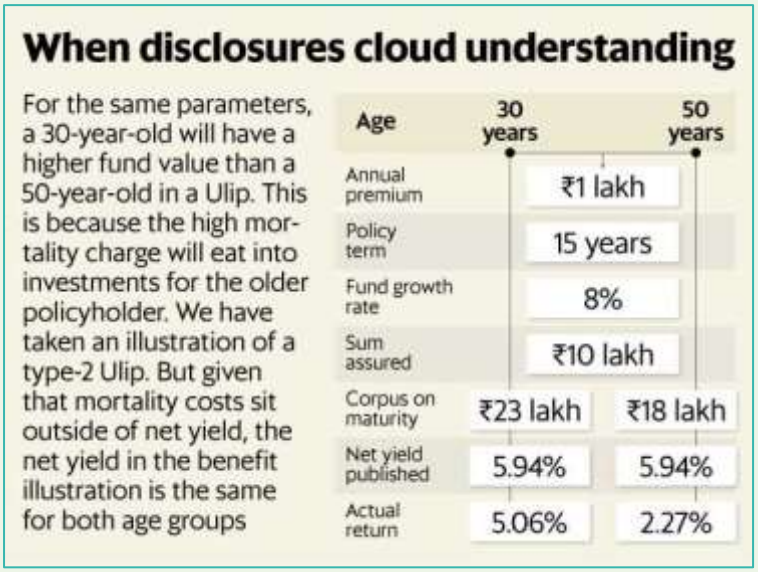
More than a decade ago, a senior citizen (then 64 years of age) bought a unit-linked insurance plan (Ulip) in anticipation of bumper market-linked returns on his investments with the added advantage of insurance. Virender Pal Kapoor, a retired scientist living in Lucknow, paid ₹50,000 towards a single-premium Ulip that came with a lock-in of five years. Kapoor was shocked to find out that in five years, his investment of ₹50,000 was reduced to ₹248 and one of the primary reasons for this dismal erosion of wealth was the mortality cost or cost of insurance that's understandably steep for older people.

Kapoor dragged the insurer to court but his experience exposes two major blind spots in regulations that govern sales practices in the life insurance industry: lack of proper disclosures and suitability assessment. Kapoor is not alone, but just one example of how a fat incentive structure coupled with lax sales regulations of complicated financial products can lead to mis-selling.

So when the latest guidelines on market conduct was put out by the Insurance Regulatory and Development Authority of India (Irdai), it felt like a huge opportunity to set some of the things right in the sales practices of the intermediaries. However, a closer look brought home huge disappointment. Mint's personal finance team that keeps consumer interest at heart has been asking for greater disclosures to improve the level of transparency in an otherwise complicated product that is the insurance-cum-savings plans. And one way to do that is to publish returns in the benefit illustration document of an insurance policy.

A benefit illustration is a year-by-year summary of costs and benefits in a bundled life insurance policy meant to help policyholders understand their investments better. In Ulips, the more transparent brethren of traditional plans, the benefit illustration gives you a detailed description of how much the insurer deducts from the premium by way of fund management charge, mortality charge and other

administrative costs; it also gives the net corpus left at the end of the year at assumed growth rates of 4% and 8%.



The idea is to show how costs eat into the fund's performance, but this simple summary of cost and benefits showcased through a benefit illustration became problematic when in 2010 the policy regulations capped the costs in Ulips by defining the maximum reduction in yield—the difference between the gross and net yields. So if the fund grew by, say, 8%, the reduction in yield, say, for a policy term of over 15 years couldn't be more than 2.25% or the net yield would have to be at least 5.75%. The regulator also made it mandatory for the insurers to show this net yield in the benefit illustration. However, this did more damage than good because the calculation of this net yield leaves out certain costs like mortality charges (cost of insurance) and guarantee charges.

Of course, for the purpose of cost caps, including insurance charges is impractical because the charge would vary depending on the age of the policyholder, but allowing for the same net yield to be showcased in the benefit illustration for, say, a 50-year-old as well as a 30-year-old, when in reality the net yield for the older person would be much lower given the high mortality cost, distorts the net return for lay investors. Kapoor, for instance, paid dearly for buying into a plan that bundles insurance by default. By allowing the same method to calculate the net yield, even in the new guidelines, the regulator is asking the policyholder to make sense of investment return by looking at the fund value accumulated alone. But imagine the confusion it will cause when you look at the paltry fund value, but an impressive net yield on the same benefit illustration? In the current scheme of things, the regulations expect the buyers to be aware and smart.

We flagged this issue way back in 2010 and have been consistently pointing out how showcasing net yield that doesn't factor in all costs does more damage than good. Nearly a decade later, nothing has changed. In fact what's also pending is a similar treatment for traditional plans especially non-participating products that guarantee investment benefits upfront. To be fair, the new rules now mandate the benefit illustrations to carry the surrender value at the end of each year, but given the high surrender costs, an improved level of disclosure should also mean showing the net return on these surrenders. In fact, an official privy to internal discussions mentioned the topic was up for debate but upon realizing that this would translate into a negative net return for many years initially, the idea to put another column of IRR (internal rate of return) next to surrender value was quashed.

Benefit illustration is a disclosure document that makes prospective customers aware of how costs eat into the investment corpus and in the spirit of disclosures; insurers should ideally disclose the actual returns. Very few insurers follow this as best practice. The regulator, of course, shouldn't bank on the insurer's intent, but hard-code rules for fair and proper disclosures. So in that sense, the recent market conduct guidelines, applicable from December, was an opportunity missed. The guidelines also talk about suitable sales, but isn't fair disclosure the first step?

(The writer is Deepti Bhaskaran.)

TOP

Source

Know how travel insurance can help you - Financial Express – 21st October 2019

Any unanticipated exigency during a trip can turn a dream destination into a financial nightmare. Your travel insurance will typically cover you for medical expenses in case of hospitalisation, flight delay or cancellation, loss of checked in baggage, loss of passport, trip cancellation, medical evacuation, etc.

Select a travel insurance which suits the nature of your travel— business travel, personal or adventure trip. You can choose your add-ons specifically if there is an adventure activity as part of your itinerary. Insurance companies provide geographic specific travel insurance plans.

Here are four major things that a travel policy helps you with:

Medical emergencies

Faced with adverse medical or accidental conditions, you may need to use your travel insurance. You can get benefits such as quick treatment or emergency evacuation to home country when required. Intimate your insurer about the situation through offered missed call facilities or toll free numbers or an email. If the claim is acceptable under the policy, the insurer can look for facilitating cashless treatment overseas which would lead to insured not being put under financial duress.

Keep all your prescriptions, reports and payment receipts safe; provide them as defined in the claim procedure, in case of reimbursement. To avoid any rejection, ensure that all these documents are duly signed, dated and stamped. In case of any accidental situation and third party involvement, you will need to submit a copy of the police report as well.

Delay of checked baggage

When travelling overseas, especially with connecting flights, loss or delay of luggage scenarios are plausible. Submit the payment receipts of basic essentials purchase that you made due to delay in baggage delivery. Get a letter from the airline confirming the delay/loss and its time? Copy of boarding pass, tickets and passport copy, PIR, baggage delivery receipt confirming travel dates are also required for receiving the reimbursement. As soon as you return from your trip, file for claim and submit required documents.

Loss of passport

You need to intimate your insurer about the loss of passport and file a police report; they can assist you in connecting with your nearest consulate office. Always keep a copy of the passport with you. Insurers also require documents like embassy and passport office receipts, identity proofs, copy of cancelled cheque, copy of new passport and emergency travel certificate and receipts of all the expenses incurred for procuring a new passport.

Trip curtailment/cancellation

One can make a travel insurance claim against the monetary loss due to cancellation or curtailment of trip. Inform your insurer about the emergency and change of plan, giving document evidence of the reason to curtail or cancel the trip, for instance, death certificate in case of a death in close family, hospital bills in case of accident or police report in case of a burglary.

(The writer is Sasi kumar Adidamu.)

TOP

Source

Centre may revamp flagship insurance schemes – The Hindu Business Line – 21st October 2019

With the Centre's flagship insurance schemes for life and accidental death and disability set to complete five years in 2020, the government is looking at increasing the risk cover and premium charges.

Sources close to the development said that Centre could hike the Rs. 2 lakh cover it provides under the Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) and Pradhan Mantri Suraksha Bima Yojana (PMSBY) from next financial year.

This could also be coupled with the long pending request for an increase in the premium amount by insurers.

"The schemes are doing exceptionally well. Over the last few years, beneficiaries are also becoming more aware about the benefits of insurance and some are realising that the Rs. 2 lakh cover is not sufficient," noted a person aware of the development.

While there have been initial discussions on the issue in the government a formal proposal and decision are yet to be taken.

"Premium for this year is already paid. The decision will now have to be taken for 2020-21, which is still some time away," noted the person. The cover period for subscribers is between June 1 and May 31 of the next year.

Another source pointed out that with the scheme set to complete five years, the government could possibly look at revamping it.

Premium hike

Coupled with it, insurers are also hopeful that their long pending demand for an increase in premium charges will also be finally agreed with.

"Costs have increased over the last four years but premium remains the same. We are optimistic that this issue will also be revisited," noted an executive with an insurance company.

Launched on May 9, 2015, PMSBY gives a one year one year accidental death-cum-disability cover of Rs. 2 lakh to all subscribing bank account holders between the age of 18 and 70 years at a premium of Rs. 12 annually per subscriber.

PMJJBY, was also launched along with it offers a renewable one-year term life cover of Rs. 2 lakh to all subscribing bank account holders in the age group of 18 years and 50 years for death due to any reason, for a premium an annual premium of Rs. 330 per subscriber.

PMSBY has about 16.6 crore subscribers as on date and has received 45,615 claims of which 35,119 claims have been disbursed.

Similarly, PMJJBY has 6.32 crore subscribers. It has received 1.63 lakh claims and has disbursed 1.49 lakh of them as on October 11 this year.

(The writer is Surabhi.)

TOP

Source

Term plan premiums: A ready reckoner – Mint – 20th October 2019

Life insurance is not about investing your money to earn a return on it, it's about financial protection for your loved ones. The most efficient way to do that is through a term insurance policy. You pay only for insurance and after the policy term ends, you don't get any money back. But on death during the policy term, it pays a huge corpus to the nominees.

Look at the premium (cost of the plan) and the claims settlement record of the insurer.

We list premium rates for some policies of a sum assured of ₹ 1 crore across three age categories for policy terms of 30, 25 and 20 years. The claims settlement rate is measured by the value of the policies as a lower settlement rate is indicative of high ticket-size policies being rejected.

Name of the Insurer	Plan	Premium in ₹ as per age (yrs) of policyholder			Claim settled (%, FY18)
		30	35	40	
Edelweiss Tokio Life Insurance	mylife+ : term	8,496	10,042	12,827	97.78
Bharti AXA Life Insurance	FlexiTerm	8,260	10,384	13,570	96.29
Max Life Insurance	Online Term Plan Plus	8,378	10,384	13,334	95.26
AEGON Life Insurance	iterm	7,497	9,512	12,717	94.56
Life Insurance Corporation of India	e-Term	17,044	21,061	26,597	94.45
Tata AIA Life Insurance	Life Insurance iRaksha Supreme	8,732	10,974	15,104	94.00
Aviva Life Insurance	i Term Smart	7,886	9,662	12,409	92.25
SBI Life Insurance	eShield	11,092	13,228	16,154	92.13
Canara HSBC Oriental Bank of Comm. Life Ins.	iSelect Term Plan	7,379	8,849	11,464	92.03
ICICI Prudential Life Insurance	iprotect smart	9,740	11,919	15,252	92.03
Aditya Birla SunLife Insurance Co. Ltd.	Online Term Plan	9,522	11,516	14,578	90.51
Exide Life Insurance	Elite Term	9,809	11,680	14,343	89.61
IDBI Federal Life Insurance	iSurance FlexiTerm	9,251	11,257	14,089	89.39
Kotak Mahindra Life Insurance	Kotak e-term Plan	8,968	11,092	14,986	88.88
DHFL Pramerica Life Insurance Co. Ltd.	Flexi E-term	7,734	9,482	12,201	88.68

Date of birth has been assumed to be 1 April in the respective year for each age group; Rates are for a male, non-smoker, Delhi-based; Claims information is for FY2017-18 for individual deaths as per Irdai's Annual Report; In ICICI Prudential and Bajaj Allianz, waiver of premium on disability is included; Sahara Life does not offer pure term plan

Source: SecureNow Insurance Broker Pvt Ltd

SANTOSH SHARMA/MINT

Source

TOP

Single mother? Build an emergency fund, buy adequate life insurance cover - Business Standard – 20th October 2019

Being a single mother in India is no mean feat. Raising the children single-handedly, balancing the roles of both mother and father, while handling the pressures of a job is truly commendable. As a single parent, they alone are responsible for the financial well-being and security of their children and their own. While they are already winning the game of life, here are a few financial tips that will help them ace the game of personal finance as well.

Start budgeting

To begin with, you must have a clear idea of what is on your financial platter. Get an idea of all the cash inflows and outflows you have. What is your family income? Are you eligible for compassionate assistance? What is the amount of alimony? Do you have any secondary source of income? Once you have compiled all the income sources, you will have a clear idea of how much is flowing in.

The next step is to check the outflows. Check for loans, EMIs, mortgage, etc. Were any investments made in your name, or were there joint investments? What are the family's fixed expenses? Make a list of these questions and answer them. By doing this exercise, you will become aware of your current financial situation and how much work is required on it. You can explore the wealth management apps available online that can help you organise your cash flows.

Build an emergency fund

Next, start setting aside a certain sum of money to build an emergency fund. This amount should be enough to take care of your kids' and your own expenses, in dire situations. Ideally, an emergency fund should equal six months' worth of expenses. Bear in mind that this fund should be used only when there is an actual emergency, such as a medical emergency or a job loss, or any other unplanned event which would require financial assistance.

Your emergency fund should be invested in highly liquid instruments that give you maximum capital appreciation. A good option is liquid funds that can offer you returns as high as 7 per cent. Go for the ones that offer instant redemption facility.

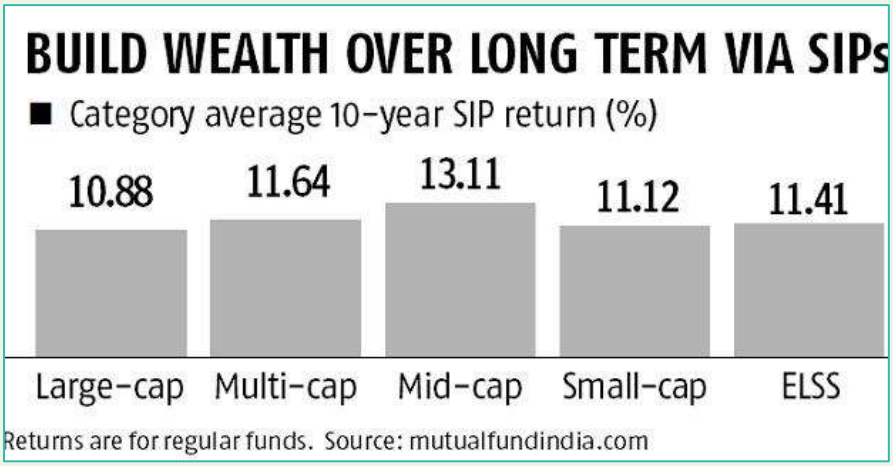
Start SIPs to meet long-term goals

Only by setting long-term goals will you be able to bring your financial life back on track. Ponder over all the major things you need to fund in the future. These may include your child's education, wedding, buying a home, buying a car, setting up a business, saving for your own retirement, or anything that you have dreamt of.

With these goals in mind, develop a plan for achieving them. How much money will they require? How much time do you have? You can club all short-term and long-term goals and start SIPs in mutual funds to gradually build up a corpus.

While debt funds work well for short-term goals, to fulfill long-term goals you can opt for a diversified equity portfolio and start investing via a systematic investment plans (SIP). You can begin with as low an amount as Rs 500 to begin with, and increase the amount subsequently. Plenty of online SIP calculators and other tools are available which you can use to find out how much you will have to invest via the SIP route each month to accumulate the required corpus within the desired timeframe.

Especially with long-term goals, SIPs are highly rewarding as you get the advantage of the power of compounding, which empowers your money to grow over the course of being invested. Power of compounding is the basic principle behind the growth of money: the amount you receive as return on your investment is added back to your principal investment every year. Thus, the interest gets compounded, generating greater returns.



You can always seek financial advice from experts. But if you plan your day well and take out just a few minutes to read and understand the financial industry and the stock market, you will be able to invest in the direct plans of mutual funds which are less expensive and give you better returns on your investments. Many online investment platforms are available that give you all the resources you need to make financial decisions by yourself as well as manage your investments, free of cost. Explore them.

Plan your taxes

One ignored area when it comes to managing finances is tax planning. A vast majority of people wait for the last minute to save taxes and often invest in avenues that may not be the best for them. Assimilate tax planning into your financial plan. Seek avenues to optimise your taxes that not only help you claim relief but also help you grow your wealth at the same time.

For instance, you can invest up to Rs 1.5 lakh in equity-linked saving schemes (ELSS) or tax saving funds. They will not only help reduce your tax outgo but will also offer better capital appreciation. You can also explore other options under Section 80C like Public Provident Fund, Sukanya Samriddhi Yojana, etc and see if they suit your needs.

Buy adequate life cover

While insurance is not an investment and should not be viewed as one, it is equally important. Getting your life covered with optimal insurance is a must these days. Get adequate life and medical insurance cover to ensure maximum financial security for your dependants.

Life insurance will ensure your kids will have sufficient funds to take care of themselves in case of an untoward event. You can arrive at the right life insurance cover by factoring in the number of dependants you have, existing loans and liabilities, existing assets and whether your children have any special needs. Term insurance should at the very least be 10-15 times annual income.

Buying health insurance will help overcome any medical incidents which may otherwise burn a deep hole in the pocket. Buy a floater health cover worth Rs 10-15 lakh, depending on what you can afford.

Amid all this, don't forget to keep some money aside for that occasional splurge. After all, what good is money if it can't buy you small joys? Be immensely proud of yourself for how far you have come and how well you have managed your life. Take small steps towards fortifying your finances and make your money work for you. Soon, you will be able to sit back, relax and enjoy the fruits of your labour.

(The writer is Harsh Jain.)

Source

TOP

Labourers should get life insurance – The Times of India – 20th October 2019

Builders should take care of daily labourers and all labourers should have life insurance, said Telangana government chief whip Dasyam Vinay Bhasker at the inauguration of a property show at Nandana Garden in Hanamkonda by Credai on Saturday.

Speaking at the event, Bhasker said that the state government is keen on developing Warangal as the second capital after Hyderabad and minister K T Rama Rao has assured that the state government will approve the Warangal master plan soon to help property developers.

TOP

Source

GENERAL INSURANCE

Road accidents: Can a tooth fracture be defined as 'grievous injury'? - The Hindu Business Line – 24th October 2019

The Indian Penal Code (IPC) will serve as a benchmark to decide what constitutes a 'grievous injury' in accidents, according to a Road Ministry official. This definitionwill be used to fix the amount that an accident victim can claim under the new Motor Vehicle Act, 2019. As per the IPC, grievous injuries include "fracture or dislocation of a bone or tooth".

As per the Motor Vehicle Act 2019, accident victims who are grievously injured can get ₹2.5 lakh within a few monthsof the accident, if they give up the right to claim higher amount in the Motor Accident Claims Tribunal (MACT). Also, in case of death of the accident victiminsurance firms have to pay compensation within a time frame, provided the victim's family agrees to accept ₹5 lakh and give up its right to go to MACT seeking higher compensation.

For the time-bound compensation payment regime to set in, the rules under the new law definingthe process have to be notified. As a result, at present, the older regime continues on how the accident victims are being compensated.

Panel to frame rules

A sub-committee — comprising representatives from Road Ministry, some States, GIC (General Insurance Corporation), IRDA (Insurance Regulatory and Development Authority), and Department of Financial Services (DFS) and transporters — is looking to frame the rules, which have to be notified for the new time-based compensation regime to set in. The committee met on Wednesday. "The rules that govern the quantum of compensation, procedure and exclusion clauses is likely be defined by the Committee," said another source in the know.

Shelling out ₹2.5 lakh compensation for all sorts of injuries – including tooth and bone fractures — is an issue the insurance companies are resisting, said a source involved in the process of making rules.

That said, stakeholders have also turned the same argument around to question the issue of putting an upper limit on compensation payout. "What if an accident victim – who is crippled for the remaining time of his life – and deserves ₹1 crore compensation, ends up getting ₹2.5 lakh just because ₹2.5 lakh was available immediately," asked SP Singh, Senior Fellow, Indian Foundation of Transport Research and Training.

At present, this is how the process works. After an accident, police has to file a report in the MACT stating the case details. After this, the MACT decides the quantum of compensation based on the victim's age, education, income and dependents.

In the run up to approval of the Act, the upper limit of ₹5 lakh for compensation was set based on an analysis which showed that the award by MACT in 75 per cent of cases where the accident victim lost his life was below ₹5 lakh, an amount that accrued to victims after a delay of one to seven years.

In fact, even the first draft of the amendment had proposed much higher compensation amounts.

(The writer is Mamuni Das.)

TOP

Source

To revive urban co-operative banks, DICGC must create corpus in Deposit Insurance Fund: Expert - The Hindu Business Line – 22nd October 2019

The Deposit Insurance and Credit Guarantee Corporation (DICGC) should create a revival and merger fund with a corpus of 10 per cent of the amount in the Deposit Insurance Fund (DIF) to ensure that banks, especially urban co-operative banks (UCBs), get support before they face solvency problems, according to D Krishna, former chief executive, National Federation of UCBs and Credit Societies.

This suggestion comes in the backdrop of the depositors of scam-hit Punjab and Maharashtra Co-operative Bank (PMC Bank) taking to the streets to get their money back.

It has been nearly a month since the RBI clamped down on the bank even as depositors are desperate to get their money back.

DIF had a balance of Rs. 93,750 crore as of March-end 2019. DICGC, which is an arm of the RBI, insures all bank deposits, such as saving, fixed, current, and recurring. The insurance cover is limited to Rs. 1 lakh only per depositor(s) for deposits held by him (them) in the "same right and in the same capacity" in all the branches of the bank taken together.

"Instead of sitting on the fund with substantial addition to it each year, a revival and merger fund with a corpus of 10 per cent of the amount in DIF can be created, which supports banks, before they get into solvency problems, and the DICGC can further reduce its payout of deposit insurance obligations as lesser number of banks will get liquidated," said Krishna.

DIF corpus

The DIF corpus has seen substantial accretion in the last five financial years: Rs. 9,840 crore in FY15; Rs. 9,800 crore in FY16; Rs. 9,900 crore in FY17; Rs. 11,280 crore in FY18; and Rs. 12,320 crore in FY19.

Krishna, who has been member of various committees of the RBI, including the high-power committee on urban cooperative banks and standing advisory committee, observed that the role of DICGC also needs to

change from an organisation that provides minimal insurance support to banks and ends up making substantial profits, to one that is actively helps banks to grow.

The co-operative banking expert felt that Section 21 of the DICGC Act must be revisited. As per this section, the corporation gets the first charge on all recoveries made by a bank under liquidation, and only after paying the DICGC the full amount of the claim paid by it, will the depositor be paid.

Krishna said the limit of amount of insured deposit must be revised upwards from Rs. 1 lakh, which was fixed in 1993, to Rs. 5 lakh, with a sub-limit of Rs. 1 lakh exclusively for savings bank accounts.

Amitha Sehgal, Honorary Secretary, All-India Bank Depositors' Association, said when banks open a customer's savings account and/or accept fixed deposits, it is in a way a contract between the banks and the depositors. Therefore, banks have fiduciary and legal obligation towards the depositors to ensure safety of depositors' funds.

"Hence, banks cannot hide behind the RBI-sponsored DICGC cover to limit their liability to only up to Rs. 1 lakh. Indeed, this deposit insurance cover is extremely low in international comparison and the fact that it was fixed way back in 1993.

"Even considering the inflation factor of the last 26 years, the deposit insurance cover should have been Rs. 5 lakh as of today," said Sehgal.

TOP

Source

Free insurance from service providers not a substitute for regular policies – Forbes – 21st October 2019

It is hard to miss an advertisement or a push for buying insurance cover wherever you go. As important as insurance is to all of us, it is also important to buy a suitable cover, and not just any available policy. It should also be for a reasonable value. But what happens if an insurance cover is offered for free? Sounds tempting, doesn't it?

It's raining free insurance offers these days.

Free covers on offer

Recently, the Indian Railway Catering and Tourism Corporation (IRCTC) introduced a free insurance cover for its New Delhi-Lucknow Tejas Express. At present, IRCTC offers insurance cover, for a fee, on e-tickets booked online, either through its app or website. Till around August 2018, IRCTC used to offer free and mandatory insurance cover to all e-ticket holders.

Uber has announced free personal accident insurance for all those who ride in its cabs. Bharti Airtel has been doling out life insurance covers of Rs 4 lakh life insurance with its Rs 249-prepaid plan. Earlier OYO Rooms announced a complimentary Rs 10 lakh personal accident insurance and baggage loss cover for all the guests staying in Oyo Rooms, Oyo Homes and other stay facilities of the group to help guests during untoward incidents of accidental hospitalisation or loss of baggage during the duration of the stay.

The latest to join the free insurance bandwagon is ICICI Bank with its complimentary Rs 1 lakh critical insurance cover encompassing 33 critical illnesses for a period of one year to all its fixed deposit (FD) holders that have fixed deposits with maturity of two or more years. Additionally, ICICI Bank has also been offering a product called 'FD Xtra' that offers a complimentary life insurance cover for a period of one year for those who invest in FDs of Rs 3 lakh or above for a period of at least two years.

On the rationale for offering a complimentary critical illness cover, Sanjeev Mantri, Executive Director, ICICI Lombard General Insurance, says, “With the emergence of lifestyle diseases amid rising medical treatment costs, a health protection cover is no longer an option, but a necessity. With the unique dual proposition offered by ‘FD Health,' you can stay covered against medical expenses, without having to liquidate your savings.”

The hope of the insurance industry is that through such small-ticket complimentary insurance products, people would get a taste of insurance and would opt for better and holistic covers in future.

“Through this partnership, we will secure Uber riders against any accident/mishap during the duration of the ride. This is an addition to our ‘satchetised' insurance solutions for providing coverage to customers according to their needs and ensure their peace of mind during the ride,” says Saurav Jaiswal, Chief Distribution Officer, Bharti AXA General Insurance.

However, experts warn that these covers might force people to believe that they have protection, but they might be caught at the wrong end as these are inadequate. “While the complimentary covers are good to make individuals aware that such covers exist, they are not reliable. Blindly relying on group insurance covers offered with other products or even employers alone is dangerous,” says Suresh Sadagopan, Founder of Ladder7 Financial Advisories.

Several debit and credit cards too offer a complimentary personal accident or purchase protection cover. For instance, SBI provides insurance cover for lost or stolen goods purchased using different SBI debit cards. So, goods that have been purchased using the card are protected in case of house-break, theft from vehicle, theft and burglary during the 90-day period from the date of purchase using the card. However, purchase of perishable items, jewellery or other precious stones is not covered.

Devil in the detail

Often, the free insurance offered with a non-financial product comes with usage and validity norms, failing which your insurance claim may not be valid.

Under the Rs 4 lakh life insurance offer of Airtel, the life insurance cover is valid only till the SIM card recharge is valid, which is for 28 days. So, the insurance cover too is available only till the recharge is active, which is too short a period for any kind of life insurance cover.

Though the personal accident cover available on credit or debit cards comes in handy at the time of emergencies, there are several clauses that need to be borne in mind.

For instance, SBI specifies that for the claim is valid for personal accident insurance, the debit card must have been used once for either a financial or non-financial transaction during the 90 days prior to the date of the accident.

Most card offers also come with a caveat that to claim insurance the flight during which the incident occurred should have been booked using the card, failing which your claim is not considered valid.

The Uber personal accident cover is valid from the point the rider enters the vehicle until the end of the trip.

So, in case of any accident immediately after stepping out of the car (say, you get knocked down just as you get off in a hurry) or prior to boarding is left uncovered and hence it is important for individuals to have a substantial cover, which is valid at all points of time irrespective of the usage of third-party products. Besides, what if your driver ‘ends' the trip (on his mobile phone) after you have been hit? Technically, you are eligible for the Uber insurance claim, but it's all very hard and cumbersome to prove that you are eligible for such a claim.

“Any piecemeal approach to risk-management will not work. Investors need to understand that free or cheaper approach may often prove expensive. One should not fall for group covers as these are usually one-year contracts and may or may not be renewed the following year by the service provider or any

outside party. Sooner they are in the net of a reliable individual insurance cover, the better for them," says Shashank Joshi, partner at Akshay Investments, warning against the ill effects of relying on inadequate covers offered by third-party products.

Claims Procedure
While the claims need to be reported to the service providers (Uber, IRCTC and so on), the payment and any discrepancies arising would not be handled by them. Hence, you would have to contact the insurance provider.

Inadequate cover
To avoid getting caught off guard, you must analyse the requirement for income protection products of life, health and personal accident insurance products, based on income, dependents, liabilities and lifestyle.

"As a thumb rule, one must have in place a personal accident cover of Rs 50 lakh to 1 crore. You should buy life insurance based on the loss of income support to your near and dear ones that could happen, if you die. Similarly, a medical insurance plan with a base cover of Rs 5 lakh and a top-up or super top-up of Rs 10 lakh would be needed in the current times, to cover hospitalisation expenses," suggests Sadagopan.

While a life insurance of 100 times one's monthly income is recommended, Joshi adds, "There are other parameters to consider such as the number of dependents one has, the life style that one follows and the liabilities (loans) that need to be repaid."

When questioned about health insurance needs, Joshi says, "The Government is offering a health insurance cover of Rs 5 lakh to below-poverty-line individuals (Prime Minister Jan Arogya Yojana, part of Ayushman Bharat) and hence one needs to have a larger cover, especially in metros where lifestyle disease risks are significant."

The hospitalisation risks today kick in at a young age too, Joshi warns, "One of my clients was recommended a Rs 30-35 lakh health insurance cover for the entire family of six. The 32-year-old later underwent an angiography and angioplasty (procedures to clear blockages in the heart) leading to a Rs 15 lakh hospital bill. So, one needs a relevant cover and to ensure optimum premium, a top-up cover can be considered."

Money control's Take
It is clear that the complimentary insurance cover offers are just ways to lure Indian customers through the tried and tested method of offering something free.

However, a life insurance cover for a mere Rs 3-4 lakh would hardly be sufficient and a validity period of 28 days or even a year is simply not enough "life" cover when you have your whole lifetime is ahead waiting to be insured.

Similarly, a health insurance cover of Rs 1 lakh might not be enough to pay for hefty medical bills when the annual medical inflation is 15-18 per cent.

A holistic protection plan needs to be prepared in consultation with a financial advisor to ensure that you reduce your out-of-pocket expenses on health insurance and your family receives the rightful amount to compensate for the unfortunate loss of the breadwinner to meet the liabilities.

But the purchase protection cover that is offered on credit and debit cards might come in handy on purchases made through the card, which may have been stolen in case you have no other home contents insurance in place. Several recent purchases aren't added to the home insurance policies by the most efficient of policyholders and you can go through the purchase period conditions and accordingly make a claim.

(The writer is Khyati Dharamsi.)

Source

TOP

For a private market in deposit insurance - The Hindu Business Line – 21st October 2019

It is nearly four weeks since the RBI froze the banking operations of Punjab and Maharashtra Cooperative Bank (PMC) Bank including restrictions on the quantum of withdrawal by depositors of monies deposited in that bank. The RBI has claimed that with the hike in the quantum of withdrawal to ₹40,000 announced on October 14, around 77 per cent of the depositors would be able to withdraw their entire savings in the bank. But there still remains a question mark over the fate of the monies held by the balance 23 per cent of the customers of the bank. They are left to agitate in front of the RBI premises on Mint Street in Mumbai or pour their tale of woe before 24/7 television news channels. Yet it need not have been reduced to all this.

Think of an alternative scenario. The RBI issues a direction under Section 35A of the Banking Regulation Act against a particular bank which puts a question mark over the safety of a customer's deposit in that bank. Far from rushing the next day morning to the bank branch, the customer leisurely walks up to the nearest branch of an ICICI Lombard or a HDFC ERGO from whom he/she has taken out a policy deposit insurance against the defaulting bank and lodge a claim for the sum assured on the ground that a direction by the RBI under Section 35A constitutes a claim event.

The case for a private market in deposit insurance stems primarily from the fact that the present system of settling deposit insurance claims under the Deposit Insurance and Credit Guarantee Corporation Act is slow and cumbersome as this newspaper had argued in a recent article on the subject (*Business Line*, October 19).

The structural reason as to why the settlement process is so time consuming is that the RBI does not segregate the process of settlement of deposit insurance claims from the process of preserving the value of the troubled bank's assets. That the insurance liability falls on its wholly-owned subsidiary, the Deposit Insurance and Credit Corporation (DICGC), doesn't help matters either.

Ideally, the banking regulator (RBI) should not also be in the business of deposit insurance protection.
Also, the DICGC bundles the role of primary insurance protection and reinsurance operation into a composite whole. This goes against the fundamental principle of risk mitigation in the insurance industry where the functions of insurance and reinsurance are usually separate depending on the size of risk exposure in individual policyholder or types of policies. If the DICGC were to act only as a re-insurer with a large number of private and public sector insurance companies offering deposit insurance protection, the process of settlement of insurance claims would be inherently faster.

There is another problem which is even more serious. The vast army of private savers in the country's banking system simply do not enjoy total insurance protection for their bank deposits. The deposit insurance which is currently pegged at ₹1 lakh is substantially below the average size of deposits in the banking system which as of March 2019, stood at roughly ₹5 lakh. In absolute terms, around ₹85 lakh crore worth of public savings in the Indian banking system is currently uninsured.

This is spread over 17.4 crore bank accounts (DICGC Annual Report 2018-19). Granted that many savers typically tend to bank with more than one institution, the number of individuals/corporates or unincorporated entities whose deposits are marginally or substantially bereft of any insurance cover is bound to be a large portion of the 17.4 crore number mentioned above.

Hike insurance cover?

The obvious solution is to hike the insurance cover. But this is something that the government is unable to do. The government's reasoning goes something like this. The banking system in most market-driven economies is highly interlinked with one another. A crisis in one institution willy-nilly ends up becoming the crisis of the entire banking industry as a whole. Should the banking industry be integrated in a greater measure with financial institutions across the globe, a distress in one with its 'contagion' effect of consequences becomes even global in nature.

In such a situation, it is beyond the capacity of any insurance institution or for that matter, even the sovereign to bail out banks across the world. The only way things can be brought back on an even keel is for the community of savers to forgo a portion of what these institutions owe to them — what the financial services industry calls a 'haircut'. The restructured institutions can then dust themselves up back to functioning as a lending institution and keep the wheels of the economy moving.

This is what the government tried to do with its Bill on Financial Resolution and Deposit Insurance of 2017. Since it would be politically suicidal to confess upfront, that there is no way out of forcing the depositors into taking a 'haircut' on the monies deposited, the legal draft on the issue was delightfully left vague while throwing in a crumb to the public in the form of a hike in deposit protection from ₹1 lakh to ₹3 lakh. But of course, the public were not fooled and the resultant furore led to the government withdrawing the Bill itself!

We thus have a situation where the government seems daunted by the prospect of having to underwrite a humongous sum of money on the implicit assumption that a failure in one bank will inevitably lead to a collapse of the entire banking industry. Since that price tag for that is currently put at ₹85 lakh crore, the government has come to the conclusion that it doesn't have the fiscal capacity for the same and has thus chosen the expedient way — kicking the can down the road to be confronted at a future date.

But the government is clearly misreading the lessons of the Global Financial Crisis of 2008. The crisis in the financial institutions of the West, back then, was due to non-ring-fencing of primary banking business from purely speculative bets on the value of financial assets whose connection to some real assets was so far removed as to make it almost illusory. This is not the case in India.

The use of derivative products by banks is not extensive and, in any case, can be ring-fenced from traditional activities of deposit taking and lending undertaken by a bank. A point to note in this context is that the extent of financial sector inter-coupling is so minimal as to be seen as practically non-existent.

The inter-bank assets and liabilities taken together, account for a tiny fraction (around 4 per cent) of the banking system's assets (loans and investments) that lie outside the banking sector (*RBI Weekly Statistical Supplement*: September 27, 2019).

Uninsured deposits

The other misconception about uninsured deposits is that a claim against such deposits will materialise all at the same time. For such a contingency to happen, the entire economy of India would have to face a total collapse from an extreme man-made or natural disaster.

How realistic is that? This is like asserting that all the 'Life' policies underwritten by LIC would result in death claims against the insurance company at one instantaneous point of time.

The phenomenon of uninsured deposits in the banking system is not without an element of irony. Both the RBI and the insurance industry regulator (IRDAI) currently permit regulated institutions to cover their assets against risk of default through the mechanism of Credit Default Swaps.

But ordinary investors have no protection for the entirety of their savings in the banking system because the public agency tasked with offering such protection is either incapable of or otherwise unwilling to secure them in its entirety. Need one say more?

(The writer is D Sampath Kumar.)

Source

TOP

Is it time to increase the bank deposit guarantee amount? – Mint – 20th October 2019

A person's aggregate deposits in a bank, including fixed deposits, are insured up to ₹1 lakh by the Deposit Insurance and Credit Guarantee Corp. (DICGC), a wholly-owned subsidiary of the Reserve Bank of India (RBI). So in case of a default by scheduled commercial or cooperative banks, DICGC will pay up to ₹1 lakh to each depositor.

After the recent crisis that hit the Punjab and Maharashtra Co-operative (PMC) Bank, there have been demands from various quarters that the deposit guarantee limit, which was last revised in 1993, be increased. Ashwini Kumar Sharma asked experts if it's the right time to do so

Anil Gupta, Vice-President and sector head, financial sector ratings, ICRA
Increase in cover to boost depositor confidence
DICGC covers only 28% of the deposit amount by value; about 92% of depositor accounts are insured. Also, about 70% of total deposits by value in the Indian banking system are with public sector banks, which are perceived to be quasi-sovereign and government's strong support will ensure safety of the deposits.

It must be noted that DICGC charges an insurance premium from banks which is 0.1% of the insurable deposits of each bank. If the amount of insurance has to be increased, then the premium charged will also increase, which in turn will either be passed on by banks to depositors by way of lower deposit rates or to the borrowers in the form of higher lending rates.

While the share of private banks has been increasing, precedence shows that failure of private banks has not led to loss for depositors.

Nonetheless, to further strengthen and improve depositor confidence, the increase in deposit insurance limit can be considered as the last revision was done in 1993 to ₹1 lakh per depositor from ₹30,000 earlier which was applicable since 1980.

Shalini Warrier, Chief Operating Officer and business head - retail, Federal Bank
Make insurance cover relevant by linking it to inflation
Deposit insurance needs deep deliberation. DICGC was formed in 1961 with a sum assured of ₹1,500 per deposit. Since nationalization of banks, mergers and acquisitions during critical junctures in the sector has helped avoid bank failures. Still, the sum assured went up by more than 6,500% to ₹1 lakh between 1961 and 1993.

To protect depositors, a few critical steps are required, including making the insurance cover relevant in the current scenario and linking it to inflation, as well as re-considering the junked Financial Resolution and Deposit Insurance (FRDI) bill.

RBI's latest figures indicate that while all bank accounts are covered under DICGC, only 28% of the total number of bank deposits are covered under deposit insurance.

However, there is another view that regardless of the bank type and the deposit amount, the premium equivalent remains the same for all and a higher cover would mean higher premiums. The one-size-fits-all approach does not price the risk appropriately, given operational quality, governance standards, ratings and other factors.

Madan Sabnavis, Chief Economist, CARE Ratings
It will ensure depositors continue to save in banks
Deposit guarantee of ₹1 lakh available at present is useful for small savers. However, if the sum of savings and fixed deposits are taken together, the amount of insurance cover will tend to be very low for households which normally park most of their savings in these accounts.

It is normally assumed, and quite rightly too, that banks will never fail and hence there is an implicit guarantee, which leads to the assumption that bank deposits are totally safe. While this may be true for public sector banks, it isn't for other banks. This risk has never been highlighted because we have not had instances of commercial banks failing, leading to depositors losing money as such banks are normally merged with stronger ones with RBI's intervention.

There is a need to increase the insurance limit for deposits. As deposits are the base that provide banks with lending opportunity, there has to be maximum protection. The limit can be increased to ₹5 lakh. Explicit insurance should definitely be provided for a larger amount to ensure that deposit holders continue to channel their savings to banks.

LovaiiNavlakhi, Managing director and Chief Executive Officer, International Money Matters
People need to be aware of risks related to bank deposits
If you invested ₹1 lakh in a bank in 2009 for 10 years at the then prevailing rate of 7.75% per annum, the cumulative amount would be ₹2.10 lakh today. So the amount covered under deposit insurance in 2009 would not be covered now. Going by this example, the amount under coverage would have to be doubled every 10-12 years, even if interest rates drop to 6% per annum.

From a depositor's point of view, this is warranted and right, but from DICGC's point of view, the costs of increasing it will skyrocket. The way out is to ensure financial literacy at the grassroots level—ensure that depositors are aware of all the risks in bank deposits. Some of these risks are reinvestment risks (interest rate on renewal may not be the same), single product investment risks (much like buying a single stock with all your wealth), and erosion of real returns on account of tax and inflation.

One way can be to hike the guaranteed amount to ₹2 lakh now; and reduce that to ₹1 lakh again in five years, as the investing public becomes financially more literate. Goal-based planning always works.

(The writer is Ashwini Kumar Sharma.)

TOP

Source

Is deposit insurance working as it should? – The Hindu Business Line – 19th October 2019

Bank depositors often have to endure long waits in limbo before they are able to get their hands on the insurance money

The Indian saver's enduring faith in bank deposits has taken hard knocks lately. First there was the string of disclosures from public sector banks on legacy bad loans that they had ever greened. Then came the revelation that many private sector banks had also chronically under-reported dodgy loans. Recently, the RBI's directions against Punjab and Maharashtra Co-operative (PMC) Bank have opened a Pandora 's Box on funds diversion and weak supervision at urban co-operative banks.

The immediate reaction from most commentators to these events has been to demand that the RBI raise the deposit insurance cover for banks from the current limit of Rs. 1 lakh per depositor, to a more liberal

limit of say Rs. 2 lakh or Rs. 5 lakh. Some campaigners are even demanding 100 per cent insurance coverage.

A revision in India's bank deposit insurance cover, which is way below global averages, is long overdue. But if the campaigners believe that a bigger cover will be enough to provide succour to hapless depositors who've trusted their life savings with dubious banks, they're far off the mark.

Directions limbo

History shows that in India, depositors in troubled banks often endure multi-year waits and surmount many hurdles before they get their hands on the insurance money.

Bank deposit insurance payouts in India kick in only after the RBI cancels a bank's license and appoints a liquidator for winding up of its matters.

For depositors in co-operative banks, troubles usually start with the RBI unearthing some evidence of mismanagement or misreporting by the bank and passing directions on it. These include curbs on the bank's lending, investing and deposit-taking activities accompanied by stringent limits on depositors withdrawing their money.

But several years can elapse between the RBI passing its first set of directions on a bank and finally making up its mind to cancel its license. In the meantime, depositors are usually stuck in limbo — neither able to access to their deposits nor file insurance claims.

It was in March 2001 that the RBI issued its first set of directions restricting withdrawals from Madhavpura Mercantile Co-operative Bank, which went belly up after lending to the infamous Ketan Parekh. It took 11 years for RBI to finally cancel the bank's license in June 2012, paving the way for depositors to get their insurance payout. In these 11 years, the bank came up with multiple proposals to restructure its operations, all of which failed spectacularly.

For over two lakh depositors in the Bengaluru-based Amanath Co-operative Bank, under RBI directions since April 2013, it has been a wait without end. After initially freezing withdrawals at Rs. 1,000 per account for six months, the RBI tried to cobble together a merger of the ailing bank with Canara Bank in 2014. After the merger fell through, depositors have been left high and dry with the RBI extending its restrictions dozens of times without assigning any reasons.

There are literally thousands of depositors in co-operative banks currently under the RBI's watch, who have been frozen out of their bank accounts for years.

While the RBI's keenness to explore every option to revive an ailing bank is understandable, the unending wait that its directions impose on depositors is unfair. The RBI must set fixed timelines for revival efforts at troubled banks, failing which liquidation will automatically proceed. It also owes depositors regular updates on the status of resolution efforts.

Liquidation troubles

Even after a bank's license is officially cancelled by the RBI and its liquidation is set in motion, depositors of failed banks may face interminable waits for their insurance pay-outs.

According to the rulebook, when the RBI cancels a bank's license, it must immediately direct the Registrar to appoint a liquidator. Within three months of his appointment, the liquidator is supposed to hand over a claims list of all eligible depositors to the Deposit Insurance and Credit Guarantee Corporation (DICGC). The DICGC is required to pay the insured amounts to the liquidator within two months of receiving this list.

While these rules envisage depositors receiving their claims within five months, the real-life experience tends to be vastly different. Data from the DICGC suggests that on an average in the last five years, deregistered banks took anywhere from eight months to eight years to settle their first set of claims to their depositors. While the DICGC seems to adhere to timelines, the claim settlement process often runs into roadblocks at the liquidators' end.

In some cases, the claims process is stalled by poor maintenance of depositor records or their seizure by investigators. In others, rogue managements do their utmost to scuttle resolution by filing suits against merger or liquidation plans. Some liquidators also present half-baked records to the DICGC, requiring much toing and froing.

These factors could explain why despite dozens of co-operative banks failing over the years, the DICGC has been paying out only modest sums by way of insurance claims. From the time of its inception until March 31, 2019, the DICGC has paid out a cumulative Rs. 296 crore to depositors of 27 failed commercial banks and Rs. 4,822 crore to depositors of 351 failed co-operative banks. That's less than Rs. 15 crore in average payouts per bank.

Clearly, it is time to hold bank liquidators accountable to fixed timelines on the liquidation process, similar to those specified under the IBC.

Is the fund enough?

So far, given the modest demands that have been made on it, the DICGC has faced no challenges in meeting demands for insurance claims from failing banks. With annual claims often undershooting its premium collections of Rs 11,000-12,000 crore from member banks, its Deposit Insurance Fund has steadily grown to stand at Rs. 97,319 crore by March-end 2019. There has also been no reason to revise the flat rate of premium levied on member banks, set at 10 paise for every Rs. 100 of assessable deposits.

But the question really is if the Deposit Insurance Fund would be up to the task, if it was faced with more frequent claims, or hit by multiple large co-operative or commercial bank failures in the same year.

In developed countries such as the US, this problem has been solved by regulators assigning comprehensive risk ratings for banks covered by deposit insurance and levying differential premia based on each bank's risk rating. In case of default, premia for the entire class of banks are immediately hiked to disincentivise risk-taking. Drawdowns from the insurance fund are promptly refilled through higher premia or contributions from the central bank. There's also regular stress-testing on the ability of the fund to weather systemic failures in the banking system.

It is not as if Indian regulators aren't aware of these developments. Several RBI-appointed committees — from the Narasimham committee on reforms in 1998 to the Jasbir Singh committee on differential risk premiums in 2015 — have thoroughly gone into these aspects to suggest drastic reforms to India's archaic system of deposit insurance. But apart from a half-hearted attempt to introduce some of these ideas in the (shelved) FRDI Bill in 2017, these proposals have not seen the light of the day.

Reforms on all these counts need to accompany an increase in the deposit insurance cover, to make sure that the Indian savers' faith in the banking system isn't lost for good.

(The writer is Aarati Krishnan.)

TOP

Source

HEALTH INSURANCE

Premium recovered from employees for parents' mediclaim not liable to GST: Maharashtra AAR - The Hindu Business Line – 23rd October 2019

A Goods and Services Tax (GST) ruling has held that recovery of medical insurance premium from salary of employees for parents' Mediclaim would not be liable to GST. This decision will benefit the salaried class.

The ruling was given recently by the Maharashtra Authority for Advance Ruling (AAR). Although such rulings do not have precedent value like that of a High Court or Supreme Court verdict, they can be used as a persuasive tool in similar matters. Such rulings are binding on the applicant and jurisdictional tax officers.

Mumbai-based Jotun India Private Ltd ('Applicant') had approached AAR for a ruling on applicability of GST on premium recovered from employees. The applicant introduced parental insurance for employees' parents as an optional scheme where the company initially pays the entire premium along with taxes to the insurance company.

Later half of the premium was to be recovered from the employees opting for the scheme. Now, the applicant wanted to know whether GST is payable on recovery of 50 per cent the insurance premium from the salary of the employees. It is clear that the applicant is not providing any services to its employees but just recovering half of the premium for the services rendered by the insurance company.

The law says that services by an employee to employer is the course of or in relation to his employment are not treated as a supply of services. However, since the applicant recovers certain amount from its employees against the insurance premium, doubt is raised on whether the same will result in 'supply of service' and GST will be required to be paid on the same.

The law specifies the activities or transactions, that are treated neither as a 'Supply of Goods' or a 'Supply of Services.' Apart from services by an employee to the employer, the list includes services by any court or tribunal, functions performed by MPs/MLA/Municipality Councillors/Members of local authorities, duties performed by Constitutional authorities, duties performed by Chairman or Members of the Committees set up by Centre or States and services of funeral/burial/crematorium/mortuary including transportation of dead bodies.

After hearing the arguments, the AAR said that the applicant is not in the business of providing insurance services. Since, there is no statutory requirement of providing parental insurance cover for the employees' parents; the non-provision of the same would not affect the business of the applicant. Thus, the activity of recovery of 50 per cent of the cost of insurance premium cannot be treated as an activity done in the course of business or furtherance of business.

Further, the activity of providing mediclaim policy for the employees' parents does not satisfy the condition prescribed in the law required to be held as 'supply of services' and it is not covered under the term 'business' as defined in the law. Accordingly, the AAR ruled that said the activity cannot be treated as supply of services between an employer and an employee.

According to Harpreet Singh, Partner in KPMG, this is an important ruling which has gone into the essence of the transaction. Any revenue cannot be held to be liable to GST unless the same is towards a supply and the activity has been done in the course or furtherance of business. "However, it would be interesting to see if this ruling can be applied to all recovery made from employees," he said.

(The writer is Shishir Sinha.)

TOP

Source

Health Insurance: Keep your heart secure with a Cardiac Plan - Financial Express – 22nd October 2019

Health is wealth and taking care of one's health is the most important thing. But lately, the modern, fast-paced lifestyle we lead is taking a great toll on people's health. As a result, 61% of deaths in India today can be attributed to the incidence of Non Communicable Diseases (NCDs) such as Cancer, Diabetes and Heart ailments. Sedentary lifestyles and unhealthy eating habits are contributing to the rising number of people afflicted with heart disease. In 2016, there were an estimated 62.5 million years of life lost prematurely due to CVD (Cardio Vascular Diseases) in India. Until a few years ago, heart ailments were a concern for people in their 50s, but now they have begun to affect people in their 20s and 30s.

People understand that being diagnosed with a heart condition in one's youth can have devastating effects both physically and financially. In addition to this, the burden of treatment, rising medical costs and the fear of losing one's hard-earned income due to treatment costs can leave one medically and financially vulnerable. The average cost of treatment of common cardiac diseases in private hospitals in India ranges between Rs 1,50,000 and Rs 6,00,000 apart from the monthly expenses on medications.

A disabledworld.com report says that life expectancy in India has increased by more than 10 years in the past 20 years. With both the life expectancy rates and the number of youth being prone to heart ailments increase, it is now becoming imperative to choose specific cardiac-related policies, because a standard mediclaim policy many a time does not offer cover for patients with heart disease.

However, with many policies available in the market, there are certain aspects that one needs to keep in mind so as to ensure maximum coverage when it comes to one's heart health. One should make sure that one's cardiac-related policy covers:

Expenses on Catheterization, Surgical & Medical Procedure:
It is absolutely vital to purchase heart-related plans that cover both surgical and medical expenses. So, when an insured has to go for procedure like stenting, angioplasty or by-pass, all the expenses are covered under the policy. A small percentage of them may develop complications warranting extended stay which involves cost.

Pre-Existing Ailment:
Very often, it is difficult to get a health insurance cover because of certain pre-existing ailments such as heart diseases. Also, some health insurance policies do not cover pre-existing ailments. But, a heart-specific health insurance policy also covers those who have undergone stenting, by-pass procedure or angioplasty. These plans not only cover the hospitalisation cost, but the medications, out-patient expenses and all daycare expenses are covered as well.

Long-term Cover:
With life expectancy rising and people suffering heart ailments early on in their lives, the requirement of long term medical treatment to secure one's future health is also growing. Hence one should look for a policy that offers coverage for not just the first-time treatment, but also provides protection against all such afflictions in the future.

Non-cardiac Ailment:
It is a common belief that cardiac-related health insurance policies only cover heart-related ailments, but cardiac-related policies also cover hospitalization expenses for all diseases covered in a mediclaim policy.

In short, a cardiac-related health insurance policy is a boon for patients who have ailments related to the heart. It ensures that whatever the condition, one is prepared to take care of their heart and of their loved ones too.

(The writer is S. Prakash.)

TOP

Source

Ayush should be covered under Ayushman Bharat, provided there are explicit treatment standards – Financial Express – 22nd October 2019

Given how the government has been a staunch advocate of strengthening alternative medicine under the aegis of the Ayush (Ayurveda, yoga, Unani, siddha, and homoeopathy) ministry, it is rather odd that these forms of treatment have been kept out of cashless insurance coverage under the Pradhan Mantri Jan Arogya Yojana (PMJAY). While the Ayush ministry, as per a report in Hindu Business Line, has proposed the inclusion of 19 Ayurveda, Unani and Siddha, eight yoga and six naturopathy treatments under PMJAY, health ministry officials seem to believe that including these under the scheme could lead to fraud, given how it would be difficult to control for leakages in a scenario where it is "difficult to ascertain that hospitalisation is for correct purposes".

While the ailments for which the Ayush ministry is seeking inclusion under PMJAY, including mental illnesses like clinical depression, can be treated or managed with allopathic treatment, bringing Ayush treatment under PMJAY is a key step towards encouraging alternative medicine. Experts say the lack of standardisation in treatment within Ayush disciplines means anybody can open up a centre and bilk the government and patients. The government must pay heed to this. Given how most alternative medicine is proprietary—for instance, the composition of most ayurvedic medicines is based not just on texts, but also on the practitioner's own tweaking of recipes—this will be a difficult proposition.

Against such a backdrop, the Ayush ministry working with AIIMS to develop protocols for specific treatments, or using findings of scientific research to bolster evidence of efficacy, will help in the long run. The ministry, meanwhile, needs to focus on compiling treatment templates from the texts and making them available to the National Health Authority to make a stronger case for inclusion.

TOP

Source

NHA report recommends common hospital registry for Ayushman Bharat – Mint – 21st October 2019

There should be a unique common hospital registry, empanelment process, grading of hospitals and package cost harmonization for effective utilization of healthcare infrastructure under Ayushman Bharat PMJAY (Pradhan Mantri Jan Arogya Yojana), a report by the joint working group of the Insurance Regulatory and Development Authority (IRDAI) and the National Health Authority (NHA) has recommended.

The report said the individual hospital empanelment process followed by health care schemes and private insurance currently leads to replication of various activities and contributes to inefficiency and duplication. "It is recommended to have common empanelment portal which can be utilized by all the schemes/insurance companies with standardised empanelment criteria will be hugely beneficial with special focus on standard safety and quality parameters," the report said.

The report has also proposed preparing a standard grading system for hospitals, based on quality parameters. It said the same grading system can be used by PMJAY and the private insurance market.

“An exercise should be done to agree on these common grading parameters in discussion with National Accreditation Board of Health also," the report said. It also recommended developing a roadmap to get one common list of accredited verified hospitals for the entire industry.

Comparative study of packages, their rates and mapping to uniform codes and defining standards and indicators for safe and quality healthcare to patients were the other suggestions made.

(The writer is Neetu Chandra Sharma.)

TOP

Source

Premium hike: Your health insurance may soon cost 10-15% more – Moneycontrol – 21st October 2019

Health policy premiums may soon see a 10-15 percent increase with insurers being asked to cover additional ailments from October 1. This will be applicable to new policies filed and sold after this date.

The Insurance Regulatory and Development Authority of India (IRDAI) recently issued guidelines barring insurers from denying a health insurance policy for genetic disorders, mental health procedures, puberty and menopause-related illnesses, among others.

"Since there is a rise in the number of ailments, the cost will go up for the additional diseases to be covered. New policies that will be filed will see an immediate premium increase of at least 10-15 percent," said the head of underwriting at a health insurer.

As part of its regulations on standardizing exclusions in health insurance, IRDAI listed out several instances where a health cover cannot be denied. Take mental health care for instance. The Mental Healthcare Act 2017, which came into force from May 29, 2018, mandates every insurer to ensure medical insurance for mental health ailments.

As per the law, this would be similar to a regular health insurance available for physical illnesses. However, the number of products available are far and few in between. IRDAI has also gone deeper and said that even if the use of a drug, stimulants or anti-depressant impacts intellectual facilities of an individual, they are entitled to get covered.

Due to a lack of adequate data, it is likely that these niche covers for mental health will cost at least 25 percent more than a standard health insurance policy. From October 1 all policies filed cannot have the prohibited items in its exclusions. This will mean that all the new policies will be subject to additional premium.

Health insurance policies are priced depending on the coverage and the list of ailments included. Those like genetic disorders and mental health do not have adequate historical data for insurers to price products that include these ailments. Hence, insurers compensate by charging a higher premium.

In the next three to five years, depending on the claim incidents and payouts, there is also a possibility that the premiums could be revised downwards. Unlike other insurance policies, which are usually considered push products, companies said a large number of policyholders are opting to buy medical policies voluntarily. This is due to the 18-19 percent rise in medical inflation.

(The Writer is M Saraswathy.)

TOP

Source

Health Insurance rule change: This 3-month new rule will impact your claims – Financial Express – 21st October 2019

At the time of buying health insurance, the insurance companies do not provide coverage to ailments or diseases from day one, that the policyholder is already suffering from. Any such medical conditions are known as pre-existing diseases and are covered only after a specific waiting period.

As per the current health insurance rules, the insurers need to cover the pre-existing ailments after a waiting period of 48 months, some insurers in some of their plans allows a lower waiting period of 24 or even 36 months.

The Insurance Regulatory and Development Authority of India (IRDAI) have recently brought about a change in the definition of pre-existing diseases in the health insurance plans. "The major change in the definition of Pre-Existing Diseases (PED) is that now even after the issuance of the policy, if the policyholder is diagnosed with any ailment within 3 months of the issuance, then the same ailment or disease will be considered as a PED upon the disclosure of the policyholder."

As of now, Pre-Existing Disease is defined as, "Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer."

New rule for Pre-Existing Diseases

As per the new IRDAI rules, effective October 1, 2019, Pre-existing Disease means any condition, ailment, injury or disease:

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or
b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.
c) A condition for which any symptoms and or signs if presented and have resulted within three months of the issuance of the policy in a diagnostic illness or medical condition.

The new definition will apply to all health insurance products including group covers filed on or after October 1, 2019.

But, what if a policyholder hides medical information and does not disclose the existence of pre-existing diseases at the time of buying? "If the policyholder does not disclose the PED at the time of Policy buying or even after the 3 months of the issuance, their policy can get rejected providing they have filed the claim for hospitalization because of the same ailment. This is only until a maximum period of 8 years of a policy. After 8 years, a claim cannot be rejected."

A proper and honest declaration is a part of the application form signed by the policyholder. Hiding information may result in a repudiation of the claim at a later stage even if it is a PED.

If you are porting your health insurance policy from one insurer to another, make sure the benefit of the waiting period of PED (the residual time period) is also carried forward on to the new insurer.

(The writer is Sunil Dhawan.)

TOP

Source

New laws to make health insurance user-friendly – The Hindu – 20th October 2019

In order to make health insurance available to all, the Insurance Regulatory and Development Authority of India (IRDAI) recently introduced certain new laws in order to make health insurance more user-friendly.

To start with, a committee report that restricts exclusions under a health insurance policy has been introduced which are completely customer-friendly. Specifically, IRDAI issued a draft to introduce a standard health insurance plan for all with a basic sum insured of ₹50,000 to ₹10 lakh, as per the requirement of the customer.

The minimum age of entry for buying the policy will be 18 years and the maximum age will be 65 years. The plan will be indemnity-based with lifelong renewability option.

Alternative medicine

IRDAI also mandated that the standard health insurance plan will also provide coverage for expenses incurred on alternative treatment such as AYUSH, which includes homeopathy, Ayurveda, Siddha or Unani. The expenses, though, will completely be subject to fixed and standard sub-limits on the sum insured.

Another major proposal submitted is a four-year waiting period for inclusion of any ailment in the health cover against the current waiting period which is for two years. However, for some conditions such as hypertension, diabetes and cardiac problems, the waiting period must be reduced to 30 days. Moreover, in order to ensure that the people suffering from pre-existing diseases, including those with disabilities, get proper health insurance, the insurers will include permanent exclusions with due consent of the customer.

Also, insurers will not be allowed to question the claims of the policyholder on the ground of non-disclosure. However, this will only be applicable after eight years of continuous renewals by the policyholder. However, the policy would be entirely subject to all clauses, including sub-limits, co-pay and deductibles as mentioned in the policy contract.

Mental health

With the aim of making mental healthcare available to all, IRDAI has directed insurers to include mental illnesses to be included in all regular health insurance policies. IRDAI made it quite clear that insurers cannot deny coverage to policyholders who have used opioids or anti-depressants in the past. Also, insurers cannot deny coverage to people with a proven history of clinical depression, personality or neurodegenerative disorders, sociopathy and psychopathy.

It was often noted that a certain group of patients including cancer survivors, epilepsy patients and many others with specific permanent physical disabilities are denied medical coverage due to their severe health conditions.

Further, all health conditions and illnesses acquired after the issuance of policy, apart from those not covered under the policy contract (like infertility and maternity), will now be covered under the policy. There are numerous major ailments that cannot be permanently excluded.

Some of the important and major diseases that must be added to the list include Alzheimer's, Parkinsons, AIDS/HIV and morbid obesity. With all these changes in place, it is a good time to review your insurance portfolio and make sure that all health related risks are covered by the insurer.

The writer is Amit Chhabra.

Source

TOP

The rise of Made-for-Millennials health insurance - The Economic Times – 20th October 2019

Health insurance in India is set for an upgrade as it transforms for India's most influential and biggest customer segment by age. Millennials, who have upended how we shop and singlehandedly given rise to the sharing economy, are now rewriting the rules for health insurance in the country. As it turns out, this couldn't have happened at a better time. GOQii's India Fit 2019 report, Insurance: An investment in health indicates millennials in India could be hurtling to a future filled with lifestyle diseases like diabetes and hypertension. Young Indians are sleeping less, eat out more often and their stress levels are rising. With hectic lifestyles compounded by spiralling health care costs, they are increasingly viewing health insurance as a necessity. According to the report, 85% believe they should get health insurance before the age of 30. But as any millennial will tell you, health insurance as their parents bought it, is a dead investment.

In an accelerating shift, millennials are now stepping up their pursuit of wellness. They are moving towards a preventive mindset, which leans away from traditional health insurance offerings built on a reactive response to medical emergencies. So what is millennial looking for in a health insurance product? Strap on a wearable and take a look through their lens.

Adulting can wait, health and wellness can't

Fun fact: Wearables crossed the 100,000 unit's shipments mark for the first time in Q3, 2018, according to International Data Corporation (IDC). This was on the back of double digit growth for two successive quarters. Health and fitness-conscious millennials are fuelling the wearable's revolution in the country. When it comes to health insurance, this same set of consumers is showing a proactive interest in staying healthy, with the longer term goal of avoiding critical illnesses. We see millennials asking for comprehensive wellness plans that bring together features like preventive health check-ups, stress management, nutritional guidance and even gym memberships! In other words, coverage that mirrors their daily priorities or life goals.

Globally, 'interactive' policies that track health data through wearables and incentivize consumers who stay healthy are catching on. It's a trend waiting to take off in India. In a six-city survey Max Bupa conducted in 2018, 43% of respondents told us they expect an increase in coverage with no increase or just a marginal increase in premium, for achieving fitness targets. 60% of potential buyers said they were willing to pay for inclusion of preventive health checks. GOQii's India Fit report reiterates this shift, reporting that 70% are willing to share health data to get discounts on insurance. This new wave of customers is looking for deeper value, where better health outcomes are visible and run parallel to any investment they make in their health.

The digital state of mind: Instant, Convenient, Personalized

Digital native millennials have a comfortable relationship with technology. This we know. There's every convenience in their phones – the streaming app, the food delivery app, the grocery shopping app, all just a click away. Now, they want the same services on demand in health insurance. But rather than competing with the plethora of health apps out there, insurers will have to stay laser focused on what is relevant to the customer. Booking doctors' appointments online and personalized health coaching were among the asks from younger customers, which we built into Max Bupa's Go Active app. The product proved instantly popular with millennials. 82% of policies were bought by customers under 35% in the first 90 days after the launch in 2018.

Young Indians are looking for digital care and services from their insurer. This could be tests results delivered in their inbox. Policy renewal and claim filing features on an app, combined with live assistance

should they need it. Concierge health services, if they are busy professionals. Location and time-sensitive offerings like real-time appointments with a specialist in their locality during an emergency. Or even gamification, to help them reach a fitness target. These are the kind of 'need-based' solutions insurers will have to respond with, leaning on technology to connect the dots within the ecosystem. Artificial Intelligence and Machine Learning will not just be used to streamline processes or identify at-risk patients in health insurance. For marketers, technology will do the heavy lifting to personalize the experience and push up engagement. With millennials, there's no one-size-fits-all. Marketers will have to thoughtfully leverage data to personalize communication, have meaningful conversations with customers and deliver the right product to the right customer at the right time.

The new-age customer experience

Millennials have their own language that health insurers will have to learn to speak. They want information, but without the overload – the sweet spot, where bite-sized information is delivered when and where it is required or useful. They are looking for a simplified, more efficient customer journey, with easy to understand policies. Insurers will have to raise the bar to provide a more high-touch, simpler and consistent customer experience and service from here on.

Millennials we talk to understand the value of protection. Health insurance is on their priority list, but just not right now – the new bike or holiday can't wait! We've seen success by engaging them early, having longer conversations with them and talking to them at their own pace. All the while, providing them with information they need and value. Young Indians want the conversation to be authentic to their lives, aligned to their needs and interests. Tapping into this very vast segment of 440 million millennials in India and keeping them happy has an upside. Research, and our own experience, shows millennials are more likely to recommend a product or service by word of mouth. Equally, they rely on word-of-mouth recommendations.

Insurers have a potentially massive opportunity ahead, as they shape and market products for millennials. Reaching this new, younger audience in a way that captures their imagination, could exponentially increase penetration of health insurance. Meanwhile, the reward for millennials who triggered this change will be outsized. Beginning with good health.

(The writer is Anika Agarwal.)

TOP

Source

Health Insurance: 4 things to look for while opting for a critical illness cover – Financial Express – 19th October 2019

Rajdeep Awasthi was 47 when he got diagnosed with diabetes. He then decided to get himself a health insurance cover. However, his health insurance proposal got rejected. "Before offering me a policy, I was told to get a series of tests done," says Awasthi. His application was then rejected by the insurer following the results, as he was considered unfit for a basic health insurance plan.

Generally, people like Awasthi are rejected by insurers for getting a health insurance cover given their high-risk conditions, old age and illness like diabetes. This is where people go wrong. They try to get a policy after getting an illness when it's too late. Many people face the same problem as they don't realize that buying health insurance becomes tougher and policyholders end up paying more as premium once they have been diagnosed with a disease.

However, catering to such cases and people, there are disease-specific plans. For instance, policies especially for diabetes and cancer. These plans offer cover even to those individuals who have been diagnosed with a critical illness. However, they come at extra cost.

Things to look out for while opting for a critical illness cover;

Inflated premium rates

The premium of disease-specific plans is very high. Hence, it is advised to policyholders to go for a basic health insurance policy first. The premium for these policies are comparatively low. Also, after opting for a normal policy that comes with a waiting period, it covers everything after a waiting period of usually four years. However, if an illness is out of control, then one should buy an illness-specific plan.

Co-Payment and sub-limits

It is commonly seen insurance policies to have these clauses, sub-limits, and co-payments. Co-payment is the percentage of the expenses that the policyholder needs to share with the insurer, in case a claim is raised. The policyholder has to pay the percentage allotted to him while buying the policy from his/her own pocket. The rest of the share is paid by the insurer. Sub-limit, on the other hand, is the limit up to which the insurer pays for some of the expenses included in the policy.

Waiting period

For disease-specific policies, there is no such thing as a waiting period. For instance, a cancer policy will cover the illness from the first day, and other diseases such as dengue, a minimum waiting period of 15 days are applicable. However, normal health insurance policies include waiting periods ranging from 2-4 years depending on the type of illness.

Certain Treatment limits

There are cap amounts that the policyholder can claim up to for a particular surgery. With this clause, even if your sum insured is a huge amount, for a particular surgery or illness you will be restricted to only a certain amount with such caps. Try to find out about such clauses it is better to ask the insurer while buying the policy which illnesses are excluded in the policy.

(The writer is Priyadarshini Maji.)

TOP

Source

These new health insurance rules to benefit senior citizens. Here's how – Mint – 19th October 2019

In its attempt to make insurance customer-friendly and more standardised, the Insurance Regulatory and Development Authority of India (IRDAI) has announced a number of changes in health insurance policies. From now on, customers will have an option of paying their health insurance premiums in various installments. Earlier, health insurance companies used to collect insurance premium on an annual basis. IRDAI has also asked insurers to increase the maximum age limit field for health insurance policies. Usually, the maximum age limit of health insurance policies is up to 65 years.

Now, one has the option of paying health insurance in various installments — monthly, quarterly or half yearly. Terms and conditions of the insurance shall remain unchanged, said IRDAI. However, the free-look period for monthly or quarterly premiums will be lower than what you get while paying annual premiums. The free-look period is a short period in which a new life insurance policy owner can terminate the policy without penalties. Depending on the insurer, a free-look period often lasts 10 or more days.

IRDAI's call to introduce the option of multiple premium payment options is a welcoming change, believes most customers. It will be especially beneficial for senior citizens. Premiums of health insurance is linked to the age of the insurance buyer and gradually increases as the buyer ages. So, opening a new health insurance policy at the age of 60 will cost you more than starting an insurance at the age of 30.

"A customer with age of 60 and above will have to pay a relatively higher premium amount, this could cause a strain in the finances," said Sanjay Datta, Chief – Underwriting, Claims, Reinsurance and Actuary, ICICI Lombard General Insurance Company Ltd.

"Having the option to pay the premium monthly/ quarterly options ensures that the customers are able to pay the premiums and continue to enjoy the benefits of their health policy," Datta added. IRDAI has allowed insurance companies to increase the maximum age of buying a health insurance. Insurers will also have the option of lowering the minimum age of investing in a health cover.

Health insurance companies can increase or decrease premiums by 15%, caused due to the modifications, based on the loss-ratio numbers said IRDAI. Health insurers are allowed to introduce additional distribution channels for particular products. The insurance companies do not have to wait for regulator's approval.

(The writer is Anulekha Ray.)

Source

TOP

Concerns in covering alternative therapies in PM-JAY - The Hindu Business Line – 18th October 2019

Two pet ministries of Prime Minister Narendra Modi – Ministry of Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH) and Ministry of Health's National Health Authority which runs Pradhan Mantri Jan Arogya Yojana (PM-JAY) are not on the same page, when it comes to practicing 'integrative medicine.'

Currently, PM-JAY — cashless insurance up to ₹5 lakh for poor families — only offers hospitalisation based on allopathic medicine. However, the AYUSH Ministry is keen on pushing alternative treatments in the scheme.

A Health Authority official said that inclusion of AYUSH packages in PM-JAY is not feasible currently. "It will be too difficult to work our way around fraud control in AYUSH procedures, where we will not be able to ascertain if hospitalisation is for correct purposes," said the official.

AYUSH Secretary Vaidya Rajesh Kotecha said that even though such an inclusion has not happened yet, the Ministry is trying hard to get the packages included. "We will help the NHA with adequate fraud control mechanisms," Kotecha added.

Last month, AYUSH Minister Shripad Yesso Naik had said that a total of 33 packages had been sent to the Health Authority for consideration to be included under PM-JAY.

Proposed packages

The list of pacakges proposed by AYUSH, seen by *Business Line,* includes 19 Ayurveda, Unani and Siddha, eight Yoga and six Naturopathy treatments. These are treatment of respiratory disorders such as asthma, pneumonia, gastrointestinal problems like hepatitis, stomach ulcers, cardiac issues like high blood pressure, metabolic disorders like diabetes, thyroid, gynecological issues like endometriosis,

reproductive tract infections, infertility, skin problems like vitiligo, psoriasis, neurological disorders like mental retardation, Parkinson's, Alzheimer's, Dementia, eye problems like diabetic retinopathy and glaucoma.

It also proposes to include mental health issues such as clinical depression, anxiety, manic disorders, and other miscellaneous illnesses like varicose veins, diabetic foot in the in-patient hospitalisation packages. AYUSH Ministry has proposed a flat rate of ₹4,000 per day for hospitalisation in a routine ward, and has said that the average length of stay of a patient could be 14 days costing ₹56,000 and could extend up to 28 days costing ₹1.2 lakh. Similarly, cost for Yoga and Naturopathy related to above disorders has been pegged at ₹1,000 for each specialty per day of hospitalisation.

According to experts, while there is a need to include AYUSH treatments for access to poor, standardisation of procedures is a must. Naresh Trehan, Chairman of Gurgaon-based Medanta Medicity said, "There is no harm in including AYUSH packages in PM-JAY, however, standardisation must be done. The authority must ascertain if a hospital is certified to mete out alternative treatments, otherwise anybody can open a centre and claim to give those treatments."

Partha Dey, Chief Operating Officer at Artemis Health Institute in Gurgaon said, "It is difficult to control fraud as of now in the scheme, even with allopathic treatments. As far as AYUSH packages are concerned equal standard setting is a must." Dey also said that there is a resistance from patients on addition of alternative therapies apart from allopathy and it causes confusion for them.

Kotecha said that while there is a popular perception that there are no standards as far as alternative treatments are concerned, this is not entirely true. "AYUSH is working with All India Institute of Medical Sciences to develop integrative model for treatment of breast cancer patients. Also, it has been seen that adding ayurvedic treatments to Tuberculosis regimen reduces liver damage. The ministry also showed evidence in Germany for treatment of Osteoarthritis through Ayurveda," he said.

However, Kotecha too agreed that there is a need to have quality services. "For this we have proposed to National Accreditation Board of Hospitals that such hospitals which provide alternative therapies should receive Entry Level Certification," he said.

(The writer is Maitri Porecha.)

TOP

Source

CROP INSURANCE

Crop insurance scheme: Few firms respond to agridept tender, delay may hit farmers in rabi season - The Indian Express – 20th October 2019

Vikas Deshmukh, a banana grower from Palsod village in Akot taluka of Akola district, has not been able to insure the 40 acres of banana plantation he owns yet. By this time last year, Deshmukh had paid the required premium of Rs 8,200 per acre to insure the land under the Weather Based Crop Insurance (WBCI) scheme, to protect him from crop loss due to unseasonal rains, hailstorm and other vagaries of nature.

The WBCI is part of the Pradhan Mantri Fasal BimaYojana (PMFBY), and it is extended to farmers who cultivate horticultural crops. The norms for WBCI, such as the amount of premium and the risk factors considered, are slightly different.

Last year, Deshmukh had received a total compensation of Rs 9. 44 lakh for his entire crop after it was destroyed by hailstorm. "Only 15 days remain till the beginning of the risk period for banana (when the insurance cover is activated)… it has never been this late," he said. But this year, Deshmukh has not been able to insure his crop yet as, he said, "the local agriculture officer said the relevant government resolution is yet to be published". For farmers like Deshmukh, the delay means that they might not be able to safeguard their crops, such as banana or grapes, before the risk period.

One of the first challenges for the next state government in Maharashtra will be the proper implementation of the PMFBY for the upcoming rabi season. Uncertainty looms large over the scheme as the Pune headquarters of the state Agriculture department has failed to receive sufficient number of bids from insurance companies to implement it in Maharashtra. Senior officers of the state Agriculture department say most insurance companies are not ready to take part inthe scheme as they fear political interference in its implementation.

A flagship programme of the central government, the majority of PMFBY premiums are paid jointly by central and state governments, while farmers only pay 2 per cent of the amount. The state is divided into four clusters and bids are invited from both public sector and private insurance companies to implement the scheme.

For 2018-19, 139.98 lakh farmers had insured 83.27 lakh hectares of their land for both kharif and rabi seasons. The total premium collected was Rs 4,778.33 crore and the compensation paid was Rs 3,730.52 crore. While 126.47 lakh farmers had taken the insurance cover for kharif season, the Agriculture department is in a fix about the scheme's implementation in the upcoming rabi season, as it has failed to get sufficient bids from insurance companies.

Under WBCI, the tender for rabi season was floated on August 31 but it had to be extended till September 16 as not enough bids were received. When the extension also failed to get the required number of bids, the department refloated the tenders on September 30. The final extension for the scheme expired on Thursday.

Similarly, for the PMFBY, the first tender was floated on September 6 and it was extended till September 26, but neither effort received sufficient number of bids. The final extension of the tender expires on October 22. Agriculture Commissioner Suhas Diwase said they were working on the matter.

Senior officers of the Agriculture department, however, said political interference and pressure from farmers' groups have made insurance companies wary about participating in the scheme. Farmers' groups have also repeatedly raised objections about the scheme and insurance companies had faced allegations of corrupt practices. "There are instances of non-insurable interests, people who don't have land opt for insurance… this puts the feasibility of the scheme at risk," said an officer.

TOP

Source

MOTOR INSURANCE

Third-party motor insurance drives up growth in premiums of general insurers – Financial Express – 22nd October 2019

General insurance companies reported 18% year-on-year (y-o-y) growth in premium (excluding crop) in September, higher than 7-11% y-o-y growth over the past three months. This was driven by the motor third-party segment (up 38%; 10-18% in past three months) as an immediate reaction of increase in traffic fines. Even as health and fire insurance business remained in a sweet spot, crop business was higher leading to 26% overall premium growth.

Most large players were strong on ex-crop basis—ICICI Lombard was up 17% (overall premium down 23%), Bajaj up 24% (overall premium up 1.4X) and SBI GI up 51% y-o-y (overall premium up 88%).

Motor third-party spikes

Motor insurance premium growth improved to 21% y-o-y in September 2019 after recording a muted 1-10% y-o-y growth in April-August 2019. Motor third-party improved to 38% y-o-y (YTD growth of 16%) due to new traffic penalties. Growth in the private sector improved to 31% y-o-y. PSUs reported muted 7% y-o-y growth, positive growth for the first time year-to-date (YTD).

Own damage business remained weak with 7% y-o-y growth for private players and 21% y-o-y decline for PSUs, leading to a 2% decline for the industry, likely indicating weak new vehicle volumes. Motor OD premiums for Bajaj, ICICI Lombard and HDFC ERGO were in line with industry trends while Acko and Go Digit remained the fastest. SBI General was up 31% y-o-y.

Rise in penalties led to sharp increase in motor third-party premium in September 2019 (up 38% y-o-y, up from 10-18% in the past three months). Growth for private players, for example, Acko and Go Digit, was up 33% as compared to 4-16% y-o-y growth in April-August 2019. PSU players reported 22% y-o-y growth compared to 3% YTD decline in 5MFY20. Among large players, SBI General and HDFC ERGO surprised with 79% growth (-9 to 36% growth in past five months) and 93% y-o-y, respectively. Bajaj was up 53%, from 11-18% in the previous three months.

Google **trends suggest peaking out**

Google trends showed sharp rise in search of the term 'motor insurance' in the last week of August. This likely indicated interest in buying motor third-party polices, as a consequence of increase in penalties for traffic violations. The trends suggest that interest has moderated and implies moderation in third-party premium in the coming months. Thus, the spike due to increase in traffic penalties may be broadly captured in.

Retail health weak

Growth in health premium accelerated to 21% on the back of strong traction in group health (up 1.3X y-o-y). Increase in tariffs in the group business attracted some private players last year; the momentum seems to be sustaining. Government schemes declined 37% y-o-y on a high base.

Retail health business was muted at 8% y-o-y (decelerating from 16% in July 2019), that too largely driven by standalone health insurers (up 23% y-o-y). PSU players reported a muted 6% growth while private players continued to report declines (down 18% y-o-y in September from 14% y-o-y in August and 7% decline in July). On overall basis, private players maintained momentum (28% y-o-y growth, higher than industry) while PSU players (18% y-o-y growth in August) ceded market share to standalone health insurers (22% growth in September).

TOP

Source

Growth in third-party motor insurance business due to strict fines - Industry Reporter – 21st October 2019

A rise in third-party motor insurance purchases was observed despite the decline in auto sales, owning to higher penalties under the new vehicles Act.

Figures suggest, vehicle sales slumped 24%, third-party motor insurance policies climbed up to 38% more. As a result, the overall insurance business also picked pace by 18%. The number is estimated to be double the 7-11% growth observed in the past three months. The total profit in motor premium (third-party and own damage) was recorded to be 21%, which is less than that of the mandatory third-party.

Experts believe vehicle owners are purchasing insurance in order to maintain compliancy and as a premium from 'on damage'. New sales were as a result down 2% for the industry.

A 22% year-on-year profit was recorded among PSU players, in comparison to 3% year-to-date decline within the first five months of the ongoing fiscal year.

HDFC Ergo and SBI General also reported 79% growth among several large players and (-9% to 36% growth within the past five months) and 943% growth year-on –year. Bajaj also rose to 53% from 11-18% in the past three months.

According to insurers, the stricter enforcement of penalties had led customers purchase mandatory third-party motor insurance. In case of two-wheelers, the Indians purchased insurance only when they buy the vehicle, which is the first year when the insurance works as a package with the vehicle purchase. Insurers believe, majority of consumers don't consider doing annual renewables thereafter. As a result of which, court had declared the regulator enforce long-term policies of five years for two-wheelers.

Based on an IRDAI'S annual report, insurance penetration in India was 3.6 %, including the share of general insurance which is 0.93%.

"India still has a huge number of four-wheelers and two-wheelers and two-wheelers that remain uninsured and the new rules will definitely drive motor insurance sales growth for the next year at least. Other reasons for the increase in motor insurance premiums this September are high class (possibly leading to more awareness) and more people opting for add-on covers," explained Rahul Agarwal, founder of broking firm Ideal Insurance.

TOP

Source

Save yourself from fake motor insurance policies – Outlook – 20th October 2019

The recently announced Motor Vehicles Act has made it mandatory to have insurance and we saw a sharp surge in people buying motor policies for the first few days of the week. While it's a good sign that people have realised the importance of having motor insurance policies, but one should be aware of fraud policies in the motor insurance segment.

The menace of fake insurance policy is greater in general insurance and particularly in motor insurance policy. Recently, finance minister Nirmala Sitharaman, in Lok Sabha, answered that in financial year 2018-19 around 1192 fake motor policies were issued amounting to Rs 53.64 crore. In the financial year, the number of fake motor policy was 498 amounting to Rs 33.74 crore, which means in last three year number of fake policies have more than doubled. According to various estimates, general insurance industry in India might be losing anywhere between Rs 3,000-3,500 crore in a year to frauds.

Rakesh Goyal Director at Probus Insurance says, "Though there are multiple frauds happening in the insurance industry. But selling of fake insurance policies is very high in the non-life industry especially motor insurance. Many times because third party (TP) of motor insurance is compulsory, large number of people buy it just for the sake of buying not from authorized agents or from insurance companies. At the time of claim they realize that they have got fake policy and claims are rejected. I would urge investors to

buy from web aggregator portals like Probus which can provide them with genuine online policies within minutes."

A few tips to avoid buying fake policies

Buy only from authorised agents and insurance companies

Just because some touts are giving you cheaper policy does not mean it's genuine. One should buy policy from authorised web aggregator or directly from insurance companies. It's always safer to buy an insurance policy directly from either authorised web aggregator or an insurance company, because any dealer or agent can easily print and give out a fake insurance policy.

Pay online or through cheque

Buy motor policies only through online payment or cheque. Avoid paying cash to agents as it might be a fake policy. In many cases one will realize they have bought fake policy only at the time of claims.

Use of the QR Code

Insurance regulator has made printing of a QR code mandatory on all insurance policies sold from December 2015. The basic purpose of this QR code is to help policyholders verify the genuineness and legitimacy of their policy. One has to simply scan the QR code on an app on your phone and it will present to you the details of your policy and of the insured vehicle.

Go through the policy

As said earlier, most people buy just for the sake of buying. If one has bought a policy from an agent they have to read the policy in totality. Fake policies are issued using wrong names and address, one should carefully read out all the details. If there are any discrepancy, they should immediately contact agent or insurance company.

Don't buy from any website

While answering the question in Lok Sabha, FM said insurance regulator has further informed that they have directly received complaints relating to three instances of fake policies being issued pertaining to entities which are not registered as general insurers with them. The details are as follows, 'M/S AKPCL General Insurance Company Ltd' (Year 2016), 'M/s Gone General Insurance (Year 2019) and 'M/s. Marines Technology' (Year 2019). Avoid buying insurance from portals which are not registered.

(The writer is Rakesh Goyal.)

TOP

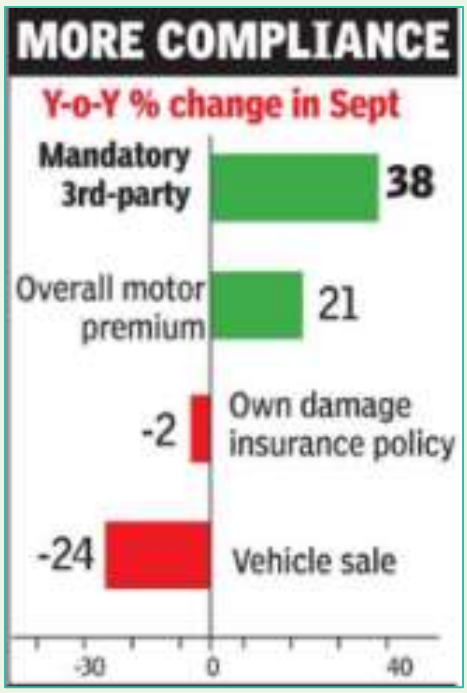
Source

Stiff fines drive third-party motor insurance business – The Times of India – 21st October 2019

Despite a severe slump in auto sales, higher penalties under the new vehicles Act led to a surge in third-party motor insurance purchases in September. Even as vehicle sales tanked 24%, up to 38% more third-party motor insurance policies were picked up, driving the overall insurance business up by 18%. This is almost double the 7-11% year-on-year growth seen in the past three months.

Non-life insurers raked in Rs 32,400 crore by way of motor insurance premium in September, up from Rs 29,871 crore in the previous month. The total growth in motor premium (third-party and own damage) was 21%, lower than that of the mandatory third-party. It is clear that existing vehicle owners are buying insurance to remain compliant as the premium from 'own damage', which reflects new sales, was down 2% for the industry.

According to a report by Kotak Securities, PSU players reported 22% year-on-year growth compared to 3% year-to- date decline in the first five months of the current fiscal. Among large players, SBI General and HDFC Ergo surprised with 79% growth (-9% to 36% growth in the past five months) and 93% year-on-year, respectively. Bajaj was up 53%, from 11-18% in the previous three months.



Insurers said that the stricter enforcement of penalties by the police has led to this massive surge in customers buying mandatory third-party motor insurance.

Under the new provisions, driving an uninsured vehicle will lead to a fine of Rs 2,000 and/or imprisonment of up to three months for the first offence, and a fine of Rs 4,000 and/or imprisonment up to three months for the second offence.

Earlier, the penalty was lower at Rs 1,000. Industry experts said compliance was higher just for commercial vehicles earlier, as they were subject to more tolls, scrutiny and checks than personal vehicles that are driven mostly within city limits.

Roughly, compliance in buying insurance is about 85% for commercial vehicles and 35-50% for personal vehicles (cars and two-wheelers), according to estimates.

"This is a positive trend as the penalty is actually higher than the cost of insuring a two-wheeler. So, this has brought a large number of uninsured vehicles within the insurance net. Own damage and personal accident insurance have also seen higher sales," said Tapan Singhel, CEO, Bajaj Allianz General Insurance Co.

"However, I am not for watering down the current regulation as some state governments have proposed. Stricter laws will mean more compliance, safer roads and fewer accidents."

Insurers said that in the case of two-wheelers, most Indians purchase insurance only when they buy the vehicle, that is, the first year when the insurance comes as a package with buying the vehicle. Majority of commuters don't bother with annual renewals thereafter. To overcome this, the court has directed that the regulator enforce long-term policies of five years for two-wheelers.

"We are seeing an increase in purchases from owners of older two-wheelers and third-party premium in this segment has doubled in September," said Bhargav Dasgupta, MD & CEO, ICICI Lombard General Insurance. He added that there were already signs that this was tapering off with some states deferring the enforcement.

According to IRDAI's annual report, insurance penetration (premium as a percentage of GDP) in India stood at 3.6% — with the share of general insurance at 0.93%. "India still has a huge number of four-wheelers and two-wheelers that remain uninsured and the new rules will definitely drive motor insurance sales growth for the next year at least.

Other reasons for the increase in motor insurance premiums this September are higher claims (possibly leading to more awareness) and more people opting for add-on covers," said Rahul Agarwal, founder of broking firm Ideal Insurance.

The writers are Rachel Chitra and Mayur Shetty.

TOP

Source

SURVEY & REPORTS

Group health claims by seniors up 52%: Report - The Economic Times – 23rd October 2019

With geriatric ailments including cataract, urinary tract infection (UTI), tumors, diabetes mellitus and thyroid disorders on rise, health insurance industry recorded a 52% increase in claims by senior citizens covered by group insurance policies, a study said.

The increase has been 40% in claims by senior citizens who have written policies individually.

West Bengal has seen the steepest rise in claims at 159%, followed by Tamil Nadu at 122%, and Delhi at 109%. While, the lowest rise in health insurance claims recorded at 54% by Goa, the study by Bajaj Allianz General Insurance said.

With average claim size ranging between Rs 60,000 and Rs 65,000, premium for senior citizens, the cost of securing with a medical insuarnce policy will rise. "We have witnessed the premium range to stay between Rs 10,000 and Rs 15,000 for an individual sum insured of Rs 5 lakh for the age band of 41-55 years, while it could go up to Rs 20,000 – Rs 24,000 for age band of 61-65 years," Gurdeep Singh Batra, head of retail underwriting, Bajaj Allianz General Insurance.

Meanwhile, the average health premium for senior citizens living in metro cities (60-63 years), stands between Rs 39,374 per annum and Rs 65,785 per annum, online policy aggregator Policybazaar.com said.

Batra said with increasing health inflation, it is advisable to have a minimum of Rs 5 lakh coverage and a Rs 10 lakh top up policy, which would give both — an adequate coverage and is an economically viable option.

With the IRDAI, introducing monthly and quarterly premium installment payment of premiums, online insurance policy aggregator Renew Buy.com's co-founder Indraneel Chatterjee, said, "It is less of a burden on the retired segment and could encourage new customers to buy health policies. Earlier senior citizens would more often default and delay renewal of health policies, due to costly health premiums paid annually. With annual premium 2x-2.5x lower for a 40-year-old male compared to a 60-year-old for sum insured at Rs 5 lakh, it is better to get insured at an early stage of life."

(The writer is Mamtha Asokan.)

TOP

Source

Non-Life Insurance Market to reach a value of INR 4,434 Bn by 2023 – openPR – 22nd October 2019

A new research document is added in HTF MI database of 60 pages, titled as 'Non-Life Insurance Market in India (2018-2023)' with detailed analysis, Competitive landscape, forecast and strategies. The study covers geographic analysis that includes regions and important players/vendors such as Agriculture Insurance Company of India Limited, Bajaj Allianz General Insurance Company Limited, HDFC ERGO General Insurance Company Limited etc. The report will help you gain market insights, future trends and growth prospects for forecast period of 2018-2023.

Summary

The non-life insurance market in India has been witnessing growth, lately, owing to the introduction of innovative products covering miscellaneous risks associated with the current market scenario. As of FY

2017, out of the 29 non-life insurance companies operating in India, 23 companies were operating as general insurers, out of which 17 are private sector companies and 6 are public sector companies, and the remaining 6 are standalone health insurers.

The insurance and re-insurance industries of India are regulated and promoted autonomously by the Insurance Regulatory and Development Authority (IRDA).

Market insights:
The non-life insurance market in India was valued at INR 1,281 Bn in FY 2017, and is anticipated to expand at a compound annual growth rate (CAGR) of ~24% in FY 2018, to reach a value of INR 4,434 Bn by the end of FY 2023. Economic growth of the country, expansion of the associated industries like automobile, and healthcare, and strengthening of the online distribution channel are contributing to the growth of the market.

The major players operating in the Indian non-life insurance market include the New India Assurance Company Limited, National Insurance Company Limited, ICICI Lombard General Insurance Company Limited, and Bajaj Allianz General Insurance Company Limited.

Product-wise segment insights:
The main non-life insurance products offered by the companies in India include motor insurance, health insurance, fire insurance, and marine insurance, among others. The motor insurance segment dominated the market between FY 2016 and FY 2017, contributing ~39% of the total general insurance gross direct premium collected in FY 2017, owing to a significant rise in the demand of automobiles (passenger vehicles, commercial vehicles, three-wheelers, two-wheelers, and quadricycles), and compulsion of motor insurance across the country.

Distribution channel-wise segment insights:
Non-life insurance policies are sold in India through individual agents, corporate agents (banks, and others), brokers, and direct business. In FY 2017, direct business transactions owed for ~31% of the overall non-life insurance policies sold in India. People prefer buying insurance policies through direct business distribution channels because of its fast and easy process.

Key growth drivers of the market:
The non-life insurance industry is driven by the growing demand for a number of associated sectors such as the automobile industry, and the healthcare industry. Total automobile production in India reached 29 Mn units in FY 2018 from 25 Mn units in FY 2017, owing to the increased purchasing power of the middle-class population, coupled with a growing young working population.

Since motor insurance is compulsory in India, growth of the automobile sector is expected to boost the motor insurance segment of the non-life insurance market in India. Apart from the automobile industry, growth in health awareness and rising inclination towards preventive healthcare are encouraging demand for the health insurance segment of the Indian non-life insurance market.

Key deterrents to the growth of the market:
The rate of non-life insurance penetration, measured as a percentage of insurance premium to gross domestic product (GDP), stood at 0.77% in 2016, which was lower than 0.80% in 2013. This implies that during 2014-2016, growth of insurance premium in India was lower than the growth in national GDP, mainly due to the capping of incentives of the brokers and agents, and supply-side problems in the associated industries. Emerging economies in Asia such as Malaysia, Thailand, and China have higher non-life insurance penetration than India.

TOP

Source

Huge gap in private, government hospital Ayushman charges: Study - The Economic Times – 21st October 2019

Huge disparities — sometimes more than 200% — in the cost of treatment have been noticed between public and private hospitals even as the government has fixed prices of packages under the Ayushman Bharat health insurance scheme, triggering further investigations by the National Health Authority (NHA) to validate reasons and formulate guidelines for private hospitals to prevent abuse.

A preliminary analysis into utilization of neonatal care packages in various states showed total spending for critical care was at least three times more expensive in private hospitals than in public hospitals.

Even in the case of basic neonatal care, the cost of treatment in private hospitals was almost double that of public ones.

Over 18,550 hospitals are empanelled under the government's flagship health insurance scheme. Of this, 54% are private hospitals and the rest are public. However, private hospitals cater to over 60% of beneficiaries under the scheme, which has recorded over 50 lakh hospital admissions within a year of its launch.

Higher participation from the private sector makes it even more important for the government to regulate cost of treatment and check any waste and abuse of resources. The scheme is designed to provide free annual health insurance cover of Rs 5 lakh to 50 crore people from 10.74 deprived families.

While average stay was higher in the case of private hospitals, they were also found mostly using special and costlier packages, whereas utilization of basic packages was common in public hospitals, the analysis showed.

For instance, the median length of stay for cases booked under the Advanced Neonatal Care Package was six days in public hospitals, whereas it was found to be nine days in private hospitals. Similarly, the average duration of stay for critical neonatal care package was eight days in public hospitals but 12.5 days in private hospitals.

"The cost of treatment is directly related to the package being blocked. In most states under consideration, public facilities mostly block the basic package priced at Rs 500 per day, while private hospitals are providing more care under special, intensive, advanced and critical neonatal packages priced at Rs 3,000 to Rs 7,000," an official said.

The study also found disparities in the amount approved for packages between states. For instance, the average pre-authorization amount approved in public hospitals of Jharkhand and Meghalaya was almost twice the average amount approved in Chhattisgarh, MP and Gujarat.

The analysis also pointed towards availability of better facilities and infrastructure in private hospitals as compared to many public hospitals. Results of preliminary audits conducted by the NHA in some private hospitals showed availability of renowned specialists, well-equipped ICU facilities and round-the-clock availability of doctors and nursing staff. However, officials said further audits and detailed investigations were required to understand the reasons behind the significant gap in the cost of treatment in public and private hospitals.

(The writer is Sushmi Dey.)

Source

TOP

INSURANCE CASES

Irdai slaps Rs 1 crore fine on Cholamandalam MS General Insurance for violating commission-paying rules – Financial Express – 22nd October 2019

Insurance sector regulator Irdai has imposed a fine of Rs 1 crore on Cholamandalam MS GIC for violating health insurance regulations related to payment of commission.

The matter relates to insurance commission paying to intermediaries during 2015-16 in violation of the Irda (Health Insurance) Regulations, 2013, which specifies that no commission shall be payable to any intermediary on acceptance of a ported policy, Irdai said its order.

It was observed that the insurer paid insurance commission to intermediaries in respect of porting-in health policies, Irdai said, citing few examples based on the cases examined for financial year 2015-16.

"The detail of commission recovery has not been provided by insurer… The violation was brought to the insurer's notice during the on-site inspection, in the exit report shared with the insurer. The violation of insurer has been continued for 586 days from the date of bringing to its notice and for 2001 days from the date of notifying the Regulations, February 16, 2013 to November 1, 2018," Irdai said.

In exercise of the powers vested in the Authority as per the provisions of Section 102(b) of the Insurance Act, 1938, the Authority hereby imposes a penalty of Rs 1 crore for the violation of Clause 15 of schedule I of the IRDA (Health Insurance) Regulations, 2013, which clearly specifies that no commission shall be payable to any intermediary on the acceptance of a ported policy, Irdai said.

The general insurer is also directed to ensure recovery of commission paid to intermediaries on ported policies and wherever recovery is not possible, the same shall be debited to shareholders' account, it added.

TOP

Source

Ombudsman asks insurance company to settle mediclaim - The Tribune – 22nd October 2019

Holding the denial of a mediclaim by the insurance company to be improper and unreasonable, the Insurance Ombudsman has directed the company to settle the claim within 30 days.

"The repudiation of the claim by the insurance company with the plea that the treatment didn't require hospitalisation is based on erroneous reasoning since the decision for the particular mode of treatment is entirely based on the treating doctor's recommendations which are further based on various other factors such as general condition, age of patient and other attending circumstances. The treatment by intravitreal injection is highly specialised treatment i.e. generally being done in operation," observed the Ombudsman.

The Insurance Ombudsman passed the orders while deciding a complaint moved by Satish Kumar Malhotra of Kidwai Nagar, Ludhiana.

The complainant has submitted that he submitted claim with the United India Insurance Company for operation of his eyes, but the same was denied. He remained hospitalised for a day in July 2017.

However, the insurance company pleaded that the complainant was treated with intravitreal injection under local anesthesia which could have been done on OPD basis and does not require hospitalisation. So the claim was not payable.

But after hearing both the parties and appreciating the evidence on record, the Insurance Ombudsman disagreed with the decision of the insurance company.

TOP

Source

Insurance companies to pay Rs 1.6 lakh to 950 passengers for Tejas delay – The Times of India – 22nd October 2019

The catering and ticketing arm of railways, IRCTC will end up paying close to Rs 1.6 lakh as compensation to around 950 passengers for delay in arrival of "private" Delhi-Lucknow Tejas Express on Saturday. However, railway ministry officials said there is no such plan to offer compensation for delay even in premium trains.

The compensation amount will be paid by the insurance companies involved in this train service. "This policy has been introduced by IRCTC for this particular train and in this case the agency has full freedom to fix the fares," said a railway ministry official.

As per reports, Tejas left from Lucknow at 9.55 am instead of its scheduled departure at 6.10 am. It reached New Delhi at 3.40 pm, a delay of more than three hours. Similarly, it left from New Delhi at around 5.30 pm instead of its scheduled departure time at 3.35 pm and it reached Lucknow at 11.30. The delay during the return trip was over an hour.

The IRCTC had announced the compensation policy specifying that each passenger will be entitled to get Rs 100, if the train is delayed over one hour and Rs 250 for more than two hours delay.

TOP

Source

PENSION

EPFO members may get an option to draw pension after 60 - The Economic Times (Delhi edition) – 22nd October 2019

The Employees' Provident Fund Organisation (EPFO) may soon give members an option to start drawing their pension once they turn 60 instead of 58 currently.

The proposal to increase the superannuation age for drawing pension under the scheme is expected to help a beneficiary grow his/her pension kitty, while also aiding the pension fund in reducing its deficit. The EPFO could also offer incentives, such as additional bonus, to those who agree to draw their pension at 60.

"Age of superannuation, which is 58 years, needs to be increased to 60 years as most of the pension funds world over, are giving pension after 65 years," the

retirement fund manager said in amendments proposed to the EPF Act, 1952. ET has seen a copy of the proposal.

EPFO is of the view that the pensionable age should be aligned to the government pension scheme and the National Pension System, where the superannuation age is 60 years.

A senior government official told ET that the proposal will be presented to the EPFO's Central Board of Trustees at the next meeting, expected in November. "Once approved by CBT, the proposal will be sent by the labour ministry for Cabinet approval," the official said on condition of anonymity.

According to the EPFO, raising the age limit will cut the pension fund's deficit by Rs 30,000 crore and will increase benefits to members since they would have two additional years of service.

As per the Employees' Pension Scheme, 1995, an employer contributes 8.33% of an employee's salary to pension, with a ceiling on pensionable salary at Rs 15,000.

"We are in support of the proposal. In fact, it should have been done long back as this will benefit pensioners with significant increase in their pensionable amount by extending the tenure for two years," said Vrijesh Upadhyay, general secretary of the Bharatiya Mazdoor Sangh.

(The writer is Yogima Sharma.)

TOP

Source

Huge advantages to switching from superannuation funds to NPS: Sumit Shukla – Mint – 21st October 2019

Budget 2019 increased the tax-free component of the National Pension System (NPS) maturity corpus from 40% to 60%. This has made NPS a compelling alternative to superannuation funds, which only have a 33% tax-free component. Sumit Shukla, CEO, HDFC Pension Fund, a pension fund manager in NPS, talks about this difference and the challenges and opportunities before NPS.

Why should anyone invest in NPS?

If you have a retirement goal, NPS should be in your basket. One big benefit is the tax benefit—whether you are salaried or self-employed. Also, the charges in NPS are very low. The tax benefit, the structure of the product, the government monitoring of the product, and investment quality given the cost, are a few reasons why you should be a part of NPS. I believe that it should be made mandatory for citizens of India—that's how we can protect future generations from a hard retirement.

The Employees' Provident Fund Organisation (EPFO) has reportedly agreed to allow EPF members to switch to NPS in return for a reverse option. What are your thoughts on this?

It is a very good idea. We have a track record of five to seven years and our returns are 10.5-11%, while EPF's return is 8.5-9%. There is an extra return you can make by being invested in NPS. EPF largely makes debt investments. In NPS, you get the opportunity of an equity allocation of 50-75%. The cost of running EPF, although paid by corporates, is 3.5-4%. If you merge it into NPS, all that cost will go away.

It's a reform that has to be done. Employees, especially younger ones, don't consider EPF a part of their investment. Instead, in the first five years of the job, if they see a sizeable NPS corpus, they will get excited about saving for retirement. Put retirement savings in one place and let the customer be the king.

A number of FinTech firms such as Paytm have got points of presence (PoP) licence. Has this caused an uptick in the flows?
It is a good initiative. NPS is a good product and they should be selling a good product. I don't think Paytm has launched their Pop yet. The problem with NPS today is that nobody sells it—banks or non-banks. Anyone who sells it will have a free run. We are welcoming it in a big way.

Pension fund manager fees are capped at 0.01% of the corpus in NPS. Does this make managing a pension fund viable?
No, it doesn't make it viable. We are all loss-making. In perpetuity, we will be loss making. The regulator is also seized of the matter. They understand that if the franchisees do not make money, they will not survive. Sooner or later, they will have to do something about making an NPS franchisee a profitable entity. At this juncture, we make 0.01%. Half of that goes as a fee to the regulator. So we actually make 0.005%. Our brokerage alone is much higher than the fees we make.

Even government pension managers, which have large corpuses, are all into debt. The regulator has to fix this. If the franchisees does not make money, they will not put the right people in research or the right kind of people in investment and subscribers will suffer. We have already seen that one entity has moved out of the business.

Some NPS equity funds have underperformed the index. Should NPS have index funds as well?
I think NPS should be actively managed. Some NPS funds have underperformed but they will catch up. Some fund managers have not put the right kind of infrastructure into place. If they had done so, they would've beaten the index. Yes, there are subscribers who want index funds. So if some innovation can be made, index funds should be allowed. You need to have both active and index funds.

The Pension Fund Regulatory and Development Authority (PFRDA) allowed government subscribers to switch pension fund managers and asset allocation several months ago. How have these reforms worked out?
They have not taken off at all because the regulator has to come back on the legacy funds (existing corpus of subscribers). Switching is only open to new employees of the government. We have got a few subscribers who have opted for us but it's not substantial in our overall assets under management (AUM).

The regulator also has to actively do marketing and canvassing with government offices to tell people that this facility is available. Otherwise no one will ever come to know that such a change has happened. People don't know how to change pension fund managers.

What difference are superannuation funds making to NPS enrolment? Are there any advantages of switching from superannuation funds to NPS?
It's a huge advantage. People are using and should use it. In superannuation funds, you get a 33% tax-free amount on retirement; in NPS, you get 60% tax-free amount. If you buy annuity from a superannuation fund, you have to pay 1.8% GST; in NPS, the GST is zero. Also, in NPS, you manage the fund.

It's a little cumbersome to move from a superannuation fund to NPS but we are seeing corporates do it. A guy who is retiring should necessarily shift from superannuation to NPS.

PFRDA hiked the cap on equity investment in NPS to 75% in 2018. Has there been an impact?
Our equity percentage of AUM has started moving up. It will take time. The enhanced cap is only available to people younger than 50. However, the process is simple and people are taking it up.

(The writer is Neil Borate.)

TOP

Source

Centre's EPFO dues surge to ₹9,115 crore amid fiscal pressure – Mint – 21st October 2019

The Union government's statutory dues to the state-run retirement fund manager has ballooned to ₹9,115 crore, reflecting the rising pressure on government finances.

The cumulative arrears to the Employees' Provident Fund Organisation (EPFO) are only till the end of March and have increased since then, a senior government official said on condition of anonymity.

Of the total dues, ₹8,063.66 crore is the government's contribution to employees pension scheme (EPS) and the remaining amount is its arrears towards a minimum pension benefit for low-wage organized sector workers, according to documents reviewed by *Mint,* and two officials familiar with the development, including the one cited above.

The issue was discussed in August and then in the following month among top officials of the retirement fund manager, who termed the situation as "worrying", the second official said. The size of the accumulated dues has prompted EPFO to go slow on a decision to raise pension for its members, the person said.

As part of the EPS scheme, the Union government offers an additional 1.16% of the pension contribution of subscribers whose monthly salary is less than ₹15,000. According to the EPF Act, an employee pays 12% of the basic salary as EPF contribution and a matching amount is paid by the employer. Of the employer's contribution, 8.33% goes to EPS and rest to the EPF corpus.

A finance ministry spokesperson didn't respond to an email on Friday seeking comment. A labour ministry spokesperson said he is not aware of any development. EPFO functions under the labour ministry.

"Since 2014-15, the Union government has not given its yearly EPS contribution. Instead, it is paying a portion of the arrears every year," the second official said.

In 2018-19, for example, the central government's share of EPS contribution was ₹5,483 crore but it didn't pay its share. Instead, it paid ₹3,900 crore of arrears.

Before 2014-15, in 2005-06 and in 2012-13, the central government held back its annual contribution though it paid a portion of its dues in each of these years, according to documents reviewed by *Mint*.

The second official said successive governments have failed to address the problem. As of 31 March 2014, the government owed EPFO ₹2,882.88 crore, which has now almost tripled.

In the case of the minimum pension, the Centre has, however, increased its payout to reduce cumulative arrears to some extent. While cumulative arrears on account of the minimum pension in 2016-17 was ₹1,198.63 crore, it reduced to ₹1,051 crore in the year ended 31 March.

EPFO does charge interest to the Union government on its arrears. "As of now, we are managing as pension outgo is not bigger than our earnings and pension corpus. If we fall short, the problem will start," a third government official said. A labour ministry official, who also declined to be named, said the ministry is regularly in touch with the finance ministry on the matter.

(The writer is Prashant K. Nanda.)

Source

TOP

Falling annuity rates: Pension regulator knocks on Govt doors seeking better deal for NPS subscribers - The Hindu Business Line – 19th October 2019

To enable NPS subscribers get better returns, pension regulator PFRDA has knocked on the Government's doors seeking certain legislative changes in the norms on mandatory annuities that need to be purchased on the 40 per cent of the accumulated corpus at the time of withdrawal.

Instead of the mandatory annuities, the Government could allow such funds (40 per cent of accumulated corpus at the time of retirement/ withdrawal) to be parked in alternative systematic return products that could fetch higher returns than current annuities, the PFRDA has suggested.

Alternatively, the PFRDA is contemplating allowing pension fund managers (PFMs) to offer annuity products on the 40 per cent accumulated corpus under the National Pension System (NPS), a top PFRDA official said.

"We are now getting feedback from NPS subscribers that they are not happy with the annuity rates. Also, the annuity rates are coming down drastically and something needs to be done on this front. So we have approached the Government seeking legislative changes," Supratim Bandyopadhyay, Whole-Time Member Finance, Pension Fund Regulatory and Development Authority (PFRDA), told Business Line .

Currently, annuity products can be offered only by annuity service providers controlled by IRDAI. PFRDA wants legislative changes to the PFRDA Act to enable NPS subscribers get a better return on the 40 per cent portion of the accumulated corpus which mandatorily has to now be invested in annuities.

"We are quite hopeful that amendments will come in the PFRDA Act during the upcoming Winter session and the changes will be a reality by December," Bandyopadhyay said.

He said NPS subscribers are not able to reconcile to the situation where annuities yield 6 per cent and the rates during the accumulation phase hovered around 9.5 per cent. "Our PFMs are ready to manage that 40 per cent also and give a better return than what annuity service providers offer. So why not give our PFMs that chance?. We only need to effect a regulation change to allow this. There is no need for law change", he said.

As on date, total NPS corpus stood at Rs. 3.8 lakh crore.

No slowdown effect

Bandyopadhyay said 'NPS private sector' is seeing a buoyant growth in terms of the number of subscribers and it has almost doubled till September to 2 lakhs on a year-on-year basis. He pointed out that NPS for 'private sector' is optional unlike the Government sector which is mandatory.

(The writer is KR Srivats.)

TOP

Source

IRDAI CIRCULARS

IRDAI issued order regarding Constitution of Committee to evaluate applications filed under IRDAI (Requlatorv Sandbox) Regulations 2019.

TOP

Source

Australia: Govt urged to subsidise health insurance for the elderly – Asia Insurance Review

The federal government has been urged to subsidise older and sicker Australians' health insurance so that private health insurance funds can make coverage more affordable to other segments of the population, according to the chief actuary of an Australian private health insurance provider.

Medibank Private's chief actuary Andrew Matthews said that the move would allow private health insurers to adjust their premiums based on risk and to reverse the decline in fund membership that follows increases in premium rates, reported The Sydney Morning Herald.

Mr Matthews said a relaxation of the rules that prevent insurers from charging higher premiums to those with chronic health conditions – with the government to help fund the difference – would entice the young and healthy with cheaper premiums and increase access to services.

"If we've got people with chronic health issues and we want to make sure they get services, then we need to fund those services – whether they're in public or private," Mr Matthews said.

"We think the funding should follow the need of the person. That would be better, because there is stronger integration between the public and private systems. In Australia, it's not very well integrated, whereas in countries like Germany, it is."

Prime Minister Scott Morrison has said his government is prepared to listen to all suggestions to arrest the slide in private health insurance membership, including a proposal by health funds for tax exemptions to allow employers to offer free health insurance to employees.

Official data show that at the end of 2018, 44.6% of Australians had hospital cover, down from 45.6% a year previously. That was a reduction of 64,000 people. 2018 was the fourth year in a row that APRA has reported a fall in rates of hospital cover, from its 2014 peak of 47.3%. The rate is now at its lowest level since December 2006.

TOP

Source

Taiwan: Fire insurance benefits to expand with premiums unchanged - Asia Insurance Review

More benefits will be made available under home fire insurance next year without any increase in premiums, the Financial Supervisory Commission (FSC) has said.

The FSC has asked all property insurance companies to automatically update the terms of their products next year, so that homeowners who have already purchased fire policies would not be worried that they would be left out, said Insurance Bureau deputy director general Ms Wang Li-hui.

According to a report in The Taipei Times, Ms Wang also said that policyholders would receive compensation if they have to move out of houses that have been too damaged by fire to live in.

This includes compensation of up to NT$100,000 (US$3,270) for moving fees, payment of up to NT$5,000 for leasing agent charges and a fixed daily compensation of NT$3,000 for the inconvenience, she said.

If they lose their credit cards, ID cards or other important documents and have to reapply, they can also receive compensation of up to NT$5,000, she added.

Current dwelling fire insurance products do not cover these losses, but the additional coverage would make fire insurance more comprehensive and helpful for consumers, she said.

New policies would also cover property losses due to typhoons or floods, with the range of compensation varying by region, she said.

Big data and risk mapping

The Non-life Insurance Association is using big data analysis to divide Taiwan into three areas.

Taichung and Hsinchu, Chiayi, Miaoli, Nantou, Changhua and Yunlin counties are classified as the low-risk group for typhoons, with residents receiving compensation of up to NT$9,000 for losses in a single event, she said.

Taipei, New Taipei City, Tainan, Kaohsiung and Taoyuan, as well as Penghu, Kinmen and Lienchiang counties are classified as the middle-risk group, with residents receiving compensation of up to NT$8,000.

Keelung and Yilan, Hualien, Taitung and Pingtung counties are classified as the high-risk group, with residents receiving up to NT$7,000, she said.

The limit on compensation for movable property damage would be raised from NT$600,000 to NT$800,000 next year, while that for property loss due to theft would rise from NT$100,000 to NT$150,000, the FSC said.

TOP

Source

Global: Major Nat CAT events to batter reinsurers' profits this year - Asia Insurance Review

Reinsurers are expected to see further erosion of their earnings this year following another year of major catastrophe losses, according to AM Best.

In a new Best's Commentary, titled, "2019 CATs Expected to Once Again Dent Reinsurance Earnings," the international rating agency says that the spate of catastrophe events may prolong the positive momentum that reinsurance pricing has experienced throughout 2019.

AM Best states that recent events such as Hurricane Dorian in the Caribbean and US and typhoons Faxai and Hagibis in Japan likely will have a meaningful impact on the profitability of and pricing conditions for global reinsurers and retrocession players.

The loss creep from last year's Typhoon Jebi into 2019 has been a learning curve for many market participants, and as a result, some reinsurers to date have been conservative in providing loss estimates.

AM Best anticipates a continuation in rate increases for the 1 January and 1 April 2020 renewal seasons, with Japan-exposed reinsurers demanding higher returns for underwriting these exposures.

Additionally, most market participants may demand higher rates to mitigate the potential increased losses in acknowledgment of a higher frequency of these larger-scale events.

Additional capacity crunch also is possible in the retrocession market. Rate increases in the retrocession space eventually should trickle down to the lower layers in the reinsurance sector, further pushing rate increases in the short to medium term.

Many insurance-linked securities (ILS) investors that have seen their capital trapped by ongoing development of the 2018 events also may face similar conditions from 2019 events. ILS managers may therefore struggle once again to replenish their funds, unless investors are granted commensurate compensation for these expected losses.

AM Best believes companies will need to maintain a strong level of discipline and demand more pricing to justify the deployment of capital in some of these loss-affected geographies.

TOP

Source

Australia: Draft general insurers' practice code requires domestic violence policy - Asia Insurance Review

The final draft of Australia's revised General Insurance Code of Practice, including a requirement for insurers to implement a domestic family violence policy, is set to be presented to the Insurance Council of Australia (ICA) board on 31 October for approval.

The new code will become mandatory following ICA board approval, and a 12-month transition period will start on 1 January.

In an address at the National Insurance Brokers Association Convention last week, ICA president Richard Enthoven set out some of the proposed code's requirements.

He said, "The new code will for the first time include a community benefit payable by members of up to A$100,000 ($69,000) as a sanction for significant breaches – a strong message from the ICA board that industry self-regulation should have meaningful sanctions."

The draft includes important new provisions that address mental health and a requirement for insurers to implement a domestic family violence policy.

The approval of the Australian Securities and Investments Commission approval will be sought for the code.

TOP

Source

Australia increases mitigation spending by A$50m to manage Nat CAT better - Asia Insurance Review

Following constant calls for a dramatic increase in funding for mitigation efforts, the senate or the upper house of Australia's bicameral parliament recently decided to increase mitigation spending by A$50m ($46.78m) on a yearly basis. This will make a significant difference to communities exposed to extreme weather and natural disasters which have become more prevalent over the last few years.

Hundreds of thousands of Australians are currently living in regions exposed to floods, cyclones, severe storms and bushfires.

According to a statement from Insurance Council of Australia (ICA) CEO Rob Whelan, investments in permanent mitigation help prevent or reduce the impact of extreme weather and are preferable to handing out money following natural disasters. This is deemed to be a better use of taxpayer funds.

"This is a timely decision, which comes at the start of disaster season. Already, many communities have felt the effect of early-season bushfires and the cyclone season is just around the corner. We are poised to assist the commonwealth in developing mitigation action plans and identifying communities where investments in mitigation will have the most impact," he said.

The ICA now urges state and territory governments also to commit to significant investments in mitigation.

"The insurance industry is standing by to reduce insurance premiums wherever permanent and effective risk reduction is deployed. Premium reductions from previous mitigation efforts have been significant to many communities and the best outcome is that these towns become more economically and socially sustainable for many generations," Mr Wheelan said.

However, he said that it is unclear what the total annual mitigation budget will be but ICA believes it will be much closer to the A$200m-a-year federal investment which was recommended by the Productivity Commission in 2014.

Around a month back, Australian Prudential Regulation Authority (APRA) said that investments in mitigation and resilience, alongside the removal of punitive taxes on insurance, were the only viable ways to reduce insurance premiums in northern Australia through reducing the physical impact to communities.

In APRA's view, the only way to drive real and meaningful change is by reducing the underlying natural peril costs which can only be achieved through avoiding or mitigating the underlying natural peril risk as reducing the risk reduces the ongoing cost.

APRA had also said that economic loss from Nat CAT is felt broadly, not only by general insurers. It impacts households, businesses and the agriculture industry taht experiences losses and needs to pay for repairs in circumstances of underinsurance and noninsurance. It also impacts others in the community as a result of disruption to economic activity and governments.

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Philippines: General insurance market to grow 25% by 2022 - Asia Insurance Review

Susceptibility to natural calamities combined with the government's push towards infrastructural investments and related insurance coverage is expected to drive the general insurance market in the Philippines to PHP112.1bn ($2.2bn) in 2022 from PHP76.6bn in 2017, according to Global Data, a London-headquartered international data and analytics company.

Global Data's report, "Strategic Market Intelligence: General Insurance in the Philippines – Key Trends and Opportunities to 2022", reveals that gross written premium in the Philippines' general insurance market registered a compound annual growth rate (CAGR) of 10.7% between 2013 and 2017. Motor, Property and MAT insurance together accounted for more than 75% share in 2017.

Pratyusha Mekala, senior insurance analyst at Global Data, said, "Government spending has a key role to play in the expansion of the general insurance business; both, in expanding the aggregate demand and procuring insurance coverage against natural calamities."

The Philippines is among the world's most vulnerable countries to natural disasters. According to the World Bank, the country faces an average PHP184.7bn of asset losses annually due to typhoons and earthquakes.

The government renewed its parametric insurance policy for coverage of PHP20.5bn in 2018. This was double the previous year's coverage and signifies the rising policy-level importance to insurance in safeguarding assets.

According to Global Data, the general insurance penetration at 0.48% in 2017 is very low in the Philippines compared to the average of developed markets (3.28%). Even emerging markets have a higher average during the same period (1.30%).

Besides conventional insurance lines, the Philippines has a rising micro insurance market that helps in expanding its coverage to lower-income households. The trend shows that it is among the fastest growing segments. As per Global Data, the gross written premiums generated from micro insurance registered a CAGR of 33.2% during 2013-2017.

Product innovations in technology, rising micro insurance market as well as the enhanced investment expenditure through government spending are expected to enable an expansion in the Philippines general insurance business.

For instance, InsurTech firm Saphron is deploying technologies such as artificial intelligence and real time data analytics for insurance underwriting and customer services.

In 2017, MAN Automotive Concessionaires Corporation launched Telematics and Fleet Management System to track drivers' performance.

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China: More young people save for retirement - Asia Insurance Review

Young people, who are between 18 and 34 years old and face stronger pressure on retirement savings amid the ageing of China's population, are saving for retirement more readily than a year ago, with the ratio rising to 48% this year from 44% last year, according to a report by Fidelity International and Ant Financial.

According to the China Retirement Readiness Survey 2019, half of all total respondents — 50,050 users of Ant Financial who are at least 18 years old — are saving for retirement this year, up from 46% a year earlier.

Though more Chinese people save for retirement with increased awareness of retirement planning, they save less — respondents are saving CNY1,052 ($148) per month on average this year, versus CNY1,389 last year, the survey showed.

"Lack of capital" was highlighted as a key hurdle to saving, as competing financial needs, especially family commitments such as securing comfortable life for parents and good education for children, are limiting respondents' ability to save for retirement.

Too late for some

Among those who are approaching retirement (or already past their desired retirement age), it remains evident that they are starting to save too late. For those who have started saving, four out of five people in the 50-59 age group didn't begin their retirement savings until they were 50 or older, giving them limited time to grow their capital.

Almost half of the non-millennials – those over 35 – haven't started saving for retirement at all. While that figure has improved from last year's survey, it shows that retirement planning remains a lower priority, even for those who may be at the peak or are close to the end of their working lives.

"In addition to general retirement awareness, people need more specific guidance and customised support to help them balance their financial priories and set their individual retirement savings goals," said Jackson Lee, China country head at Fidelity International.

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