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INSUNEWS

- Weekly e-Newsletter

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• Quote for the Week •

"Be faithful in small things because it is in them that your strength lies"
Mother Teresa

INSIDE THE ISSUE

Insurance Industry

Purchasing insurance online - Financial Chronicle – 11th June 2018

Life is full of stages events that are exciting and uncertain. But whichever stage one is in it's important to ensure that protection takes the centre stage. Life insurance is something that can protect your family's financial security should something happen to you.

A must-have for your financial plan, it also helps fulfil your needs while you are still alive – like providing supplemental income for retirement, building a corpus for future goals, child's education, marriage, a vacation abroad or a source of funds if you become ill.

But how do you opt for the right insurance if you do not have access to a skilled and knowledgeable advisor or the product is not available in your geography.

Today like any other product, life insurance is also available online and can be purchased with a single click. But the key is to keep certain critical factors in mind before opting for the product that best suits your needs.

Why purchase online: There is indeed a cost benefit attached to buying life insurance policies online. While, online purchase offers a customer ease of transaction anytime, anywhere; is quick and transparent; it also helps one buy the desired product at cheaper prices compared with the same product available offline. Life insurance products that are available online are 3-5 per cent cheaper than the ones available offline.

Besides being cost effective, online purchase of insurance products offer several benefits to the customer. The purchase is transparent and one can get all the information about the product at one place, one can compare several products in one go to make the right choice, buy products seamlessly anytime, anywhere, opt for paperless transactions, and can track the purchase real time.

Who should buy online: A person who is aware of his/her financial needs and goals, has understanding of the benefits of insurance and is familiar to online transactions should opt for online purchase. But one who is either not financially aware or don't have time to explore the insurance products online or is not used to online transactions, should opt for an agent's advice. Insurance advisors help customers in analysing their needs, offer solutions and assist in opting for the suitable product.

In case you are prompt with internet usage and online transactions, you can definitely avail the convenient mode of purchasing a life insurance policy online.

Identify your needs: First and foremost, at the time of purchasing life insurance it's important that the customer first understands his/her needs in order to identify and select the right product, reason being, insurance is a long-term product and needs complete understanding before one buys it. Once a person is conversant with his requirements and future goals he can go online, read all the offerings, understand the features of the policy, compare it with other products and purchase the one that best suits his needs.

How to buy online: Bearing in mind that there isn't any advisor to handhold you with the purchase, it's important to keep note of the following while buying a life insurance policy online.

Adequate research: There are host of products available today and in order to select the right product it's imperative to compare and evaluate them at several parameters. The three main factors being, policy features, premium (cost of the policy) and claim settlement ratio of the insurance company. Something that equally

matters is the brand of the company. Comparing policies on these parameters will ensure that you don't end up purchasing a plan that does not suit your life requirements.

Accurate information: Just like offline, even during an online purchase you would need to fill up the policy application form. It is the most important step where you will have to be extra careful and ensure correctness of all the information provided by you. It's prudent to disclose facts honestly about you and your family's medical history and give accurate details about your social habits and lifestyle. If you fail to provide these details properly, your nominee might have difficulty at the time of claim settlement. Wrong and incomplete information can lead the insurance company to deny or reject the claim completely. Hence, it is prudent to be cautious at the time of filling up the form online and avoid mistakes.

Sufficient cover & right tenure: The biggest challenge for a person purchasing insurance is to select the amount of cover and the policy term or tenure. How much is enough? You should assess your exact needs, asset-liability situation, financial condition, and savings; and then opt for the level of cover in the alignment to these factors.

Another factor to keep in mind is inflation. At the time of policy purchase you may feel that the cover will suffice, however, even an inflation of 5-8 per cent can impact negatively the value of the cover over a period. Hence, it would be prudent to go for enough cover or opt for increasing sum assured option.

Biggest mistake to avoid is to take inadequate cover for too short a tenure. The thumb rule to select the right policy term or tenure is until your retirement age. The life insurance policy should be active till your earning years and should act as a shield to your annual or monthly income. If the policy is being purchased to meet a desired goal such as child's education or a trip abroad, the term should be until the date your goals are likely to be met. Online purchase of life insurance is convenient, quicker, simpler and involves less and at times no paperwork. So, evaluate your protection need and get covered in just a click.

Source

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India: Insurance marketing firms gain in number – Asia Insurance Review

The number of registered insurance marketing firms in India have grown to 219 at present from less than 20 about two years ago, according to data from the IRDAI. On the other hand, as of April 2018, there were 2,082,000 individual agents with life insurance companies compared to nearly 2,190,000 four years ago, reports *DNA* citing Life Insurance Council data.

Viewed as a new channel, insurance marketing firms (IMFs) were created to increase insurance penetration in the country by taking insurance to the doorstep of customers. They solicit or procure insurance products, and undertake insurance service activities like undertaking back office functions of insurers. Each IMF is allowed to tie up with two life insurers, two non-life insurers, and two health insurers.

"The insurance marketing firm model allows intermediaries like ex-industry veterans to recruit other agents and sell insurance in a better way. It is early days, and you can expect the insurance marketing headcount to cross 500 in a few years," said the CEO of a private sector life insurer.

The insurers which have clear rules and a streamlined registration process and which provide dedicated channel support will likely emerge as the winners in terms of snapping up good IMFs, said the distribution head of a government-run non-life insurer. The IRDAI released regulations covering the licensing of IMFs in January 2015.

Source

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Insurance Regulation

IRDAI probes suspected illegal ways in bancaassurance biz - Business Standard – 14th June 2018

Insurance regulator IRDAI is probing suspected illegal practices by some private sector insurers and their partner banks in bancassurance channels, a senior official said. Bancassurance refers to selling of insurance policies through banks, wherein these lenders earn revenue through such sales.

It has come to the IRDAI's notice that some of the insurers are offering commission or remuneration to the bankers that is more than the maximum stipulated levels under the norms, a senior regulatory official said.

Several large insurance companies and their parent companies are maintaining current account balances with various banks which also act as corporate agents.

"The interest forgone on such large balance is counted towards the compensation banks are to receive for the sale of insurance products. Due to this practice, the interest of policy holders is at stake as these funds earn zero returns," the official said.

Such practices are in gross violation of the IRDAI's norms for bancassurance industry and standard corporate governance norms. The regulator has flagged some illegal practices in the bancassurance channels to the government and has got a g0-ahead to act against errant entities, the official said.

According to IRDAI's corporate agency regulations, if a bank and an insurance company enters into an agreement for selling insurance products, then that bank is not eligible for any payout other than commission. IRDAI has also noticed that insurance companies and their promoter organisations have engineered rates to pay excess commission or remuneration to their bancassurance partners through "seemingly" legitimate banking transactions.

"For instance, forex rates offered by a bank and its promoter group companies are higher than fair market rates," he said. The difference between the fair market rates and the actual rate paid is counted towards the "illicit fee" payable for sale of insurance products, he said.

Sometimes, insurance companies make up for marketing expenses incurred by lenders to compensate for a bank's sale incentives towards insurance products. "This is done by way of offering heavy discounts to banks on co-branded outdoor hoardings, which is ultimately charged (to) the policy holders," he said.

Source

Many insurance companies pay a fee to the banks to advertise on/ in their ATMs whereas the responsibility of bearing this fee is on the bank itself and should not be charged to the insurer. The ultimate incidence of this fee is borne by the policy holder which is illegitimate, the official added.

Back

Life Insurance

Just 1% growth in premium for pvt insurers in Apr-May - Financial Chronicle – 15th June 2018

For private life insurers, financial year 2018-19 started on a flat note as they recorded a mere one per cent growth in individual new business premium in the first couple of months.

Private life insurers underwrote an individual adjusted first year premium of Rs 3,458 crore in April and May this year compared to Rs 3,408 crore in corresponding period of last year, according to monthly data released by Life Insurance Council. The new business premium in the previous year had witnessed strong growth on account of demonetisation-related inflows.

ICICI Prudential Life Insurance (-31 per cent growth) and Bajaj Allianz Life Insurance (-6 per cent), which were the biggest beneficiaries of note ban related inflows, saw negative growth with individual adjusted first year premium equivalent (APE) of Rs 739 and Rs 179 respectively.

SBI Life Insurance grew by just 9 per cent with an individual adjusted first premium of Rs 667 crore. HDFC Life, however, reported a robust 30 per cent year-on-year growth to Rs 497 crore on account of the low base last year.

APE is a global way of calculating new business as it takes into account 10 per cent of new business single premium and 100 per cent regular premium.

Karni Singh Arha, chief financial officer at Aviva Life Insurance, explained, “In 2017-18, private life insurers had grown by 18 per cent. Barring the top three players, the growth was 25 per cent for mid-sized and small players. Post demonetisation (on November 8, 2016), the inflows into life insurance increased. If you see the cash contribution for buying insurance policies was high and a large part of new sales were single premium plans in 2016-17 compared to 2017-18.”

“Post Union budget with the introduction of long-term capital gain tax on mutual funds, life insurance capitalised on it and have sold Ulips and single premium plans in February and March. Anyways the first qu-arter is also the weakest qu-arter in terms of new busin-ess premium,” added Arha.

Private insurers saw a fall in market share to 52.5 per cent this year compared to 55.2 per cent during the two months of last year. On the other hand LIC registered a 13 per cent gro-wth during the period under review to Rs 3,127 crore.

On an un-weighted basis, the industry reported 13 per cent growth in new business premiums to Rs 9,348 crore, led by LIC which grew by 16 per cent to Rs 5,187 crore. Private insurers wrote a lot of loss making group insurance business and reported a 16 per cent growth in it to Rs 2,397 crore while LIC stayed away from this segment during the two months of this year.

Source

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Life insurance: Expect inflows into Ulips to be moderate in FY19 - Financial Express – 15th June 2018

Private life insurance companies reported 4% growth in individual annual premium equivalent (APE) (16% excluding ICICI Prudential Life and SBI Life Insurance) during May 2018 on a high base – 46% year-on-year (y-o-y) growth in March 2017. Inflows to equity mutual funds were broadly stable month-on-month but far lower than FY17 peaks. We expect FY19 to be a moderate year for Ulip inflows though focus on protection business will continue to drive value of new business (VNB) for large players. In that sense, monthly APE data is incrementally less relevant.

Private sector (excluding ICICI and SBI) individual business

Private sector APE was up 3% y-o-y in May 2018. With 16% growth at LIC, the overall industry was up 10% y-o-y. In the individual segment, the private sector was up 4%. Excluding two large players, viz., ICICI Prudential Life and SBI Life that carry a large base and have been moderating for past few months, the rest of the industry was up 16% y-o-y, lower than 21% in April 2018 and 25% in FY2018.

SBI picks up, ICICI still weak

SBI Life Insurance reported 27% growth in individual APE as compared to 11% decline in April 2018 and 12% growth in 4QFY18. The business seems to be back on track after a sluggish performance over the past four months.

ICICI Prudential Life reported 30% decline in individual APE, in line with April 2018. This comes from a high base of 100-145% growth. On a lower base (27% growth in June 2017), we expect the growth rate to be higher next month. A low base in April had supported 70% individual APE growth for HDFC Life. Business was moderate at 11% yoy growth in May 2018. Max Life was up 19% y-o-y, in line with its recent growth rates. Birla Sun Life Insurance delivered 40% growth during the month (37% in April 2018) despite a high base of 25-32% for individual APE; the traction may be likely due to its bancassurance partnership—a trend interesting to track.

We don't read much into growth rates of April-May as the first two months of the year tend to be weak and may not be indicative of any trends for the year, and second, the base for past two months was high with private sector individual APE up 86% in April 2017 and 46% in May 2017 from delayed benefits of demonitisation. Overall growth in the next 10 months was lower at 21%.

Investment inflows may be moderate in FY19

Moderation in capital markets and rise in interest rates will likely reduce the intensity of inflows into capital market financial savings—mutual fund inflows for the past two months have been stable at `132-136 billion as compared to the peak of `265 billion in August 2017. We hence expect inflows into Ulips to be moderate in FY19.

Most large life insurance companies are increasingly balancing their portfolio and shifting a bit towards traditional policies. More importantly, all large players are focusing on the high-margin protection business, which will improve their VNB even as APE growth may be lower. As such, the monthly APE trends are increasingly getting irrelevant.

Source

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Beating ULIPs? Rs 50 lakh of free life insurance cover with these mutual funds – Financial Express – 14th June 2018

Though investing in equity through mutual funds via Systematic Investment Plan (SIP) is gathering pace of late, mutual fund houses have been wary of the investors discontinuing SIPs when the stock market corrects or is volatile. So, to ensure that the investors do not discontinue the SIPs, mutual funds are now offering free life

insurance cover in case the SIP is not discontinued. At present three mutual fund houses offer it. ICICI Prudential Mutual Fund offers it as 'SIP Plus', Reliance Mutual Fund offers it as 'SIP Insure' and Aditya Birla Mutual fund as 'Century SIP'. The life insurance cover is linked to the value and tenure of SIP. It is free as the cost of group life insurance is borne by the asset management company. Let us understand how it works:

Who is eligible for this benefit

Anyone who has completed 18 years and have not completed 51 years can enrol with these mutual fund houses to avail this. Moreover, for availing this benefit, you have to specifically opt for the scheme. This benefits of free life insurance is available only on selected schemes as notified from time to time. Reliance, however, offers this facility with all the equity and hybrid schemes.

How much insurance is available

For all the three products, insurance is 10 times of the monthly SIP for the first 12 months. It goes up to 50 times for the second year for all the three products, but it is 120 times after the third year for Reliance and 100 times for Aditya Birla and ICICI.

In terms of absolute amount the life insurance cover available is capped at Rs 21 lakh for Reliance (increased to Rs 50 lakh from 1st June 2018), Rs 25 lakh for Aditya Birla and a higher of Rs 50 lakh for ICICI Pru MF. So, although in terms of the number of times of monthly SIP amount, the insurance cover for Reliance is higher, but in absolute monetary terms ICICI offers almost the double than that offered by others.

The amount of insurance is available for all the schemes taken together under the same or different folio for the first holder. Insurance is available for the first holder only and not for all the joint holders under the scheme.

When the insurance begins and ceases

The insurance cover commences after a waiting period of 45 days, but for accident there is no waiting period and it becomes available the moment the first SIP is debited. Like normal life insurance policy, the death due to suicide is covered after one year only.

The insurance cover ceases once you complete the age of 55 years for Reliance and ICICI, but for Aditya Birla it continues till 60 years. The insurance cover also ceases as soon as the tenure of the SIP is over. So, the insurance cover is available as long as the SIP continues and discontinues once the SIP discontinues.

Even if you redeem money partly or fully out of the money invested during the SIP period, the insurance cover ceases immediately. The insurance also ceases in case SIP is returned unpaid for specified number of consecutive months which vary from fund house to fund house. For ICICI it is five consecutive occasions. In case of Reliance and Aditya Birla the insurance cover will cease if the SIP is not paid on four consecutive or different occasions.

In case the SIP is stopped after 3 years, the insurance does not cease and continues subject to the maximum amount available under the scheme. However, if the SIP is stopped before the completion of thee years, the insurance cover ceases immediately.

Tenure of the SIP

For being eligible under the scheme the tenure of SIP has to be specified in advance and has to be minimum of thee years, but generally there are no restrictions on SIP continuing beyond 55 years when the insurance cover ceases.

Exit load

In case of ICICI and Reliance, if the investor redeems the investments before one year, the regular exit load, as applicable to the scheme, is charged. However, in case of Century SIP there is steep exit load of 2% if the units invested under this benefit are redeemed within one year and 1% for investments redeemed after one year, but before three years.

Benefit of the product

Since a certain sum as expressed in terms of number of times of the amount of your monthly SIP is covered under these products, you are assured that in case something happens to you during the SIP period, the goal for which the investments is being made will not get jeopardised as in case of premature death. Though the corpus of the fund invested by you may not be sufficient, but the same would be available through the insurance claim.

Though the insurance cover is free, but your choice of the fund house or scheme should not be dictated by this benefit only and the choice should primarily be based on the potential of performance of the scheme in which

Source

you wish to invest. However, in case you have equally performing schemes from all the three fund houses, you should opt for schemes of ICICI Prudential or Reliance due to a higher life insurance cover and lower exit load offered by them. If Reliance has a better performing scheme, it even scores over ICICI Pru in terms of the number of times of your monthly SIP the life insurance cover is available.

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Life insurers new premium collection grows 9 per cent in May – The economic Times – 13th June 2018

New premium collection of life insurance companies rose by nearly 9 per cent to Rs 12,838.24 crore in May compared to the same month last year, according to the Irdai data. All the 24 life insurers had written new gross premium of Rs 11,801.01 crore in May 2017.

New business premium of Life Insurance Corporation of India (LIC), the largest and the only state-owned life insurer, expanded by 9.49 per cent to Rs 9,204.88 crore in May against Rs 8,406.76 crore in May 2017, the data released today showed.

LIC has the highest market share of 67.40 per cent in the life insurance business. The remaining 23 life insurance companies collected Rs 3,633.36 crore during the month under review, up 7.04 per cent from the year ago's Rs 3,394.25 crore.

HDFC Standard Life's new premium collection was up by 30.82 per cent at Rs 790.14 crore in May 2018 compared to Rs 603.97 crore in the same month last year. SBI Life's new premium rose by 11.41 per cent at Rs 641.28 crore; Max Life by 19.63 per cent at Rs 235.11 crore; Bajaj Allianz Life by 6.82 per cent at Rs 214.25 crore, and Aditya Birla Sun Life by 37.73 crore at Rs 197.05 crore in May 2018.

DHFL Pramerica Life registered a rise of 35.13 per cent in its new business premium at Rs 121.02 crore, and PNB Met Life by 30.58 per cent to Rs 95.16 crore. New business premium of ICICI Prudential Life, however, dropped 24.51 per cent at Rs 548.56 crore; Kotak Mahindra Old Mutual Life Insurance's by 2.15 per cent at Rs 205.76 crore, and Canara HSBC OBC Life's down by 42.61 per cent at Rs 46.07 crore.

India First Life new premium was down 11.01 per cent at Rs 62.35 crore while Sahara Life's new premium fell 98.17 per cent to Rs 2 lakh in May.

Cumulatively, the gross new business premium of all life insurers rose by 7.08 per cent to Rs 20,118.22 crore during April-May of the current fiscal year. For LIC, the new business during first two months of this fiscal was up by 5.66 per cent at Rs 13,560.15 crore. Private sector players' cumulative new premium increased by 10.13 per cent to Rs 6,558.07 crore.

Source

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General Insurance

Premium of non-life insurance companies rises 10% in May – The Hindu Business Line – 14th June 2018

The total premium of non-life insurance companies saw an increase of about 10 per cent at Rs 10,516 crore in May this year, compared to Rs 9,598 crore in May 2017.

Of the total premium underwritten by non-life insurance companies during May 2018, public sector insurers garnered Rs 4,635 crore, which was down about 5 per cent, compared to the Rs 4,868 crore they mobilised a year-ago.

But private non-life companies reported a 23 per cent increase in their premium income at Rs 5,109 crore, compared to Rs 4,154 crore, according to the Insurance Regulatory and Development Authority of India (IRDAI). The combined premium of five standalone health insurers grew 44 per cent at Rs 654 crore, compared to Rs 455 crore in May 2017. Specialised PSU insurers mopped up Rs 117 crore (Rs 120 crore). In the private sector category, ICICI Lombard topped the table and saw its underwritten premium grow to Rs 1,118 crore (Rs 949 crore in May 2017), followed by Bajaj Allianz and Tata AIG, which mobilised Rs 633 crore (Rs 536 crore) and Rs 459 crore (Rs 352 crore), respectively.

Reliance General, HDFC Ergo General and Iffco Tokia garnered Rs 450 crore (Rs 322 crore), Rs 443 crore (Rs 397 crore) and Rs 417 crore (Rs 351 crore), respectively. Among the four public sector companies, New India remained the leader with a premium of Rs 1,562 crore (Rs 1,476 crore), which is a growth of 6 per cent.

United India Insurance's premium during the month stood at Rs 1,184 crore. National Insurance Company also saw a decline at Rs 969 crore, compared to Rs 1,282 crore, while Oriental Insurance garnered Rs 921 crore (Rs 799 crore).

Source

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Motor Insurance: Look beyond your car dealer to buy insurance - Financial Express – 13th June 2018

While the insurance landscape has undergone a sea change and customers are buying what they need, as far as car insurance goes, it continues to be sold rather than purchased. Many of you continue to opt for insurance ascribed by dealers because you think it is hassle-free. While this may be true, you do not realise that the premium you are shelling out is around `5,000-8,000 more in comparison to what you will be paying if you bought your car insurance online.

Therefore, you must consider the following factors when buying insurance for a brand new car.

Cost comparison

For instance, dealers charge around Rs 35,000 for a mid-size sedan with 1.6L engine. However, if you search online, coverage for similar specifications is Rs 26,000. In the case of SUVs with a standard 2.2L engine, the dealer insurance will set you back by up to Rs 70,000. However, purchasing a policy online for similar vehicle type will not cost you more than Rs 45,000.

Some of the dealers are known for encouraging you to buy insurance from them. They may suggest that you may lose your cashless claim privileges or lose certain aspects of your warranty or that insurance is free within the whole package of car purchase. This is not true.

In fact, Insurance Regulatory and Development Authority of India (Irdai) has prescribed elaborate rules in this regard and no dealer can refuse to give you cashless facility as long as your insurer has a tie-up with them. In fact, warranty is also extended by car manufacturers and the dealer has no role to play on deciding what will be covered as part of your warranty basis where you purchase your insurance.

Too many add-ons

It is seen that a pre-determined package of add-ons were given to customers irrespective of the type of usage or requirements. For example, if you are not staying in a low lying/flood prone city, engine protector may not be of much use. Similarly, if you are purchasing a car from the smaller segments, consumables cover/key & lock replacement cover may be a choice basis the premium that it commands.

If you or your family members drive the car, there is no point of taking a Paid Driver Legal liability cover. If you/family members have adequate personal accident insurance policy or have a life insurance policy with adequate accidental disability coverage, you may want to take a relook at the un-named passenger cover.

No claim bonus

Another critical factor you must consider at the time of buying insurance from your car dealer is No Claim Bonus (NCB). It is a discount on premium offered by your insurer if you do not make a single claim in the previous policy year which can go up to 50% after five claim-free years.

Some dealers at times sell insurance on the pretext of promising discounts on subsequent renewables. You are entitled to an NCB irrespective of where you purchased your policy from and it has got no correlation with your car dealer. In fact, you are authorised to an NCB even if you change your insurer in the succeeding year, as long as you have had a claim-free year. Even if you decide to change your insurer after a year, NCB bonus will be still offered as long as you have a claim-free year.

Buying a car from a dealer is the only option you may have, but this is not the case with motor insurance. It is suggested that you conduct a research on motor insurance; what features it should have, how much Insurance Declared Value it should offer and what will it cost so that you can question your insurer when he offers you an insurance plan. This way you can increase the protection offered by the insurance package at a much lower price.

Source

So, how can you buy insurance without taking physical possession of the car? The process is simple: All you have to do is call your dealer and ask for the engine, chassis number of the car you are purchasing and the RTO under which it will be registered. These details will suffice for buying the policy that you truly need for your car. Once insurance is done, the same can be shared with your car dealer, who will get your car registered.

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Health Insurance

Mediclaim scheme: Govt joins hands with third party administrator – The Times of India – 14th June 2018

The government has tied-up with a third party administrator (TPA) in a bid to cut costs on the implementation of its universal mediclaim scheme, Deen Dayal Swashtya Seva Yojna (DDSSY).

The directorate of health services (DHS) had extended its contract with M/s United India Insurance Co Ltd, and had not appointed a new agency, despite floating a tender in March. The TPA brought on board will now handle the insurance bills raised under the scheme. However, it is unclear if the government will continue with the present arrangement or curtail it after a few months.

United India Insurance was appointed when the scheme was first launched in September 2016. In March, the health department had floated a tender to select a new agency after the scheme was modified. But some senior government doctors were of the opinion that the mediclaim scheme should be discontinued as it benefitted empanelled private hospitals. There were also complaints of malpractices by certain hospitals.

Source

The scheme was later modified, and a tender was floated three months ago. The number of procedures or interventions also increased from 456, as against 447. But the bidders quoted two or three times more than its present outlay of Rs 80 crore towards the scheme. The government expected an increased expenditure by Rs 30-40 crore under the revised scheme, an official said.

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Health insurance portability: Here's how to go about it – Mint – 14th June 2018

Health insurance is important for everyone across all age groups. However, as you grow older, you may find it difficult to buy a health insurance plan. It's, therefore, important to keep your health insurance policy going by paying premiums on time.

But what if you are unhappy with your insurer and you want to change? The rules allow you to port your health policy from one insurer to another.

What can you port?

You can port your policy from one insurer to another, provided both are indemnity plans that cover hospitalisation, at the time of renewal.

You can port credits on time-bound exclusions and no-claim bonus. There are three kinds of time-bound exclusions or waiting period in a health policy: initial waiting period that applies when you first buy, waiting period on pre-existing ailments which can extend up to four years and waiting period on certain specified ailments. Let's say you decide to port your health plan after three years, and the new policy has a waiting period of two years on pre-existing ailments. Since you have already spent three years in the previous policy, the three-year credit gets ported to the new policy.

You can port only to the extent of the sum insured (including no-claim bonus) with the previous insurer. So if you had a policy of, say, Rs 3 lakh but want to port to a new insurer and also enhance the sum insured to, say, Rs 10 lakh, porting benefits will apply only for Rs 3 lakh plus bonuses, if any.

Keep in mind that the new insurer is not duty-bound to insure you as that will depend on its underwriting criteria. So if you have a pre-existing ailment or have made a claim on your policy, portability can be challenging.

How it's done?

You need to apply for portability at least 45 days before the expiry of the existing policy (and not before 60 days of the expiry of the policy).

Source

You will need to fill up a portability form. The insurance regulator keeps details of all the customers and insurers can tap into this database to understand claims record and other details. The regulator needs to provide details within seven days of the insurer placing the request. The insurer needs to inform you of its decision within 15 days. So, if the insurer rejects insuring you, you can still renew your existing policy.

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Fine on errant 'Modicare' insurers – The Times of India – 14th June 2018

The government has introduced tough penal provisions for delay in settlement of insurance claims under its ambitious Ayushman Bharat National Health Protection Scheme (NHPS). Insurance companies may have to pay a hefty penalty as interest to hospitals for delay in payment under the scheme.

According to the model tender document, if claim payment is delayed beyond 15 days, insurance companies will pay a penalty of 1% interest on the claimed amount per week. This will be paid directly by the insurer to the hospital. In case of inter-state claims or portability of benefits, the penalty will become due after 30 days.

Similar penal provisions are also applicable to state health agencies and even on the Centre if they fail to deposit their share of premium to the escrow account or release payments to insurers on time. The health insurance scheme, popularly known as Modicare, aims to cover nearly 50 crore beneficiaries from over 10.74 crore "deprived" families as per the socio-economic and caste census (SECC) data with an annual health cover of Rs 5 lakh per family per year.

Timely payments have been a major area of concern for healthcare providers. In order to streamline the payment mechanism and avoid delays similar to the Central Government Health Scheme (CGHS), the government has fixed specific time-lines for releasing payments against claims made under the scheme.

Payments to insurers will be released in three different tranches by the state health agencies from a designated escrow account. The Centre and different state governments will deposit their respective premiums into the designated escrow account.

While a hospital can complain to the state health agency if payments are not made on time, the scheme also has a grievance redressal mechanism for insurers if timely payments are not released to them. Apart from the payment mechanism, the model tender document also details the procedures and packages covered under the scheme as well as those which are not covered and the ones which require pre-authorisation.

For instance, dental procedures, congenital external diseases, vaccinations and fertility-related procedures, along with any ailment or condition that can be treated under outpatient care or OPD will not be covered under the government-run insurance scheme. The scheme will also not cover a person who has attempted suicide or self injury.

While packages covered under the scheme include pre-hospitalisation and post hospitalisation coverage along with drugs, diagnostics and food for patient, the scheme will not cover any out- patient diagnostics and vitamins etc. Moreover, pre-authorisation is mandated for key procedures including all packages under oncology, cardiology, cardiac surgery and opthalmology. In case of inter-state portability also, pre-authorisation is mandatory.

For administration of the scheme, the tender document divides states into two categories. Category A includes Arunachal, Goa, Himachal, J&K, Manipur, Meghalaya, Mizoram, Nagaland, NCT Delhi, Sikkim, Tripura, Uttarakhand, Andaman and Nicobar Islands, Chandigarh, Dadra and Nagar Haveli, Daman and Diu, Lakshadweep and Puducherry. Category B includes Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, MP, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, UP, and West Bengal.

Source

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Pre-authorisation must for nearly half of all treatments under NHPM – The Indian Express – 13th June 2018

Pre-authorisation will be mandatory for 636 of the 1,350 packages – or 47 per cent of all treatments covered under the National Health Protection Mission (NHPM), including all packages for cardiology, ophthalmology and oncology.

The NHPM will not cover conditions that do not require hospitalisation, dental procedures, congenital physical problems, vaccinations and fertility related procedures, and will also not cover treatment of a person who has attempted suicide. The Ayushman Bharat secretariat on Tuesday released the model tender documents for the scheme, which lays down every detail from the medical audits that are a mandatory part of the mission, the provision for interests to be paid by insurers in case of delays in payment, and the "administrative costs" allowed for insurers.

The document also lays down that for a claim ratio of up to 120 per cent, states will not pay any additional premium. If the claim ratio is beyond 120 per cent, the state will pay 50 per cent of the additional premium. The remainder will have to be borne by insurance companies. Ayushman Bharat (AB)-NHPM will target about 10.74 crore poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data, both rural and urban. The tender documents released are model with flexibility for states both on the mode of implementation and the rates.

Pre-authorisation is essential to keep a check on "moral hazard" procedures. "Moral hazard" in health insurance parlance is the tendency of people who are insured to buy/be sold additional healthcare interventions, irrespective of their actual needs, leading to expenses that do not necessarily add to their own health or well being but bleeds the insurer. For this reason, procedures such as emergency consultation for acute colic, high fever, cuts, stitches, soft tissue injury, single-bone fracture plaster, nebulization for asthmatic attack, moderate dehydration, hypoglycaemia in a diabetic, dengue without complication, and food poisoning will be covered in the scheme only if the treatment is availed in a government hospital.

For some specified conditions, pre-authorisation will be required for hospitalisation beyond 10 days. The penalty provisions are stiff for any delays on the part of insurer or the state health agency (SHA) either in paying premium or in processing claims or refunds to the state. If claim payment to the hospital is delayed beyond 15 days, insurers will have to pay an interest of 1 per cent for every seven days of delay.

If premium refund is not made by the insurer to SHA within 30 days of the communication for refund, there will be 1 per cent interest for every week of delay. If the premium is not paid to the insurer by the SHA within six months of the commencement of the AB-NHPM, insurers will get an interest of 1 per cent of the premium amount for every seven days' delay.

For the purpose of administration of the scheme, states have been divided into two categories. Category A states includes Arunachal Pradesh, Goa, Himachal Pradesh, Jammu and Kashmir, Manipur, Meghalaya, Mizoram, Nagaland, NCT Delhi, Sikkim, Tripura, Uttarakhand, and six Union Territories: Andaman and Nicobar Islands, Chandigarh, Dadra and Nagar Haveli, Daman and Diu, Lakshadweep and Puducherry.

States in Category B are Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, and West Bengal. To be able to bid for the category A states, an insurance company will have to have a "Gross Direct Premium Income from Health business of at least Rs 100 crore (experience of handling 25000 claims), and at least Rs 200 crore (experience of handling 50,000 claims) for Category B states in each of the last three completed financial years", according to the document.

In category A states, the administrative cost allowed is 10 per cent if claim ratio less than 60 per cent, 15 per cent if claim ratio is between 60 per cent and 70 per cent and 20 per cent if claim ratio is between 70 per cent and 80 per cent. In Category B states, administrative cost allowed will be 10 per cent if claim ratio is less than 60 per cent, 12 per cent if claim ratio is between 60 per cent and 70 per cent, and 15 per cent if claim ratio is between 70 per cent and 85 per cent.

Source

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Not all States for Ayushman Bharat - The Hindu Business Line – 12th June 2018

The country's most ambitious health insurance scheme Ayushman Bharat may not find takers in West Bengal, Punjab, Odisha and Delhi.

Interestingly, all the four are non-BJP-ruled States. Chief Minister of West Bengal Mamta Banerjee had sent top officials from the State's Health Department for a two-day consultations on the scheme.

Bengal scheme

The officials maintained that the State is already running a similar scheme, 'Swasthya Saathi' since 2017, which provides paperless, cashless and smartcard-based facilities to its citizens. Basic health cover for secondary and tertiary care up to Rs 1.5 lakh a year through insurance mode is provided under the scheme. It covers critical areas such as cancer care, neuro and cardiothoracic surgeries, liver diseases, blood disorders and so on up to Rs 5 lakh through the assurance mode already in place.

Officials in the Union Ministry of Health and Family Welfare maintain that while West Bengal and Delhi are staying away because of political reasons, the Punjab government is strapped for funds and has conveyed that it is difficult for it to make financial arrangements for the 40 per cent State share of the scheme. The Centre pays 60 per cent.

"The Delhi government has not signed up for a host of Central government programmes due to differences of opinion," said an official working in the Health Department of the Delhi government.

Hesitant Karnataka

Karnataka, too, has shied away from signing the MoU with the Centre till now. "The issues with Karnataka will be resolved soon. It is just that Karnataka is in the process of forming a new government. We are hoping that they will come on board soon," said a senior official from MoHFW.

In spite of Union Health Minister JP Nadda's claim that 14 States will sign the MoU, officials are still unsure about every State participating in the ambitious scheme that will provide cashless insurance of Rs 5 lakh to 10 crore families. "All States will attend the consultation on June 14, but we are still unsure which of these will sign the MoU," said Union Health Secretary Preeti Sudan.

Source

Back

Govt to sign MoUs with "maximum" states this week for Ayushman Bharat: JP Nadda - The Economic Times – 11th June 2018

The union health ministry will sign memoranda of understanding with a "maximum" number of states on June 14 to launch the Prime Minister's ambitious scheme to provide health protection to 100 million families, said health minister JP Nadda on Monday. These states are expected to include Gujarat, Uttar Pradesh, Bihar, Chattisgarh, Madhya Pradesh and Jharkhand, according to data shared by the health ministry. At the moment, five states and union territories are yet to confirm whether they would be implementing the Ayushman Bharat National Health Protection Mission (AB-NHPM) scheme.

This includes states like West Bengal and Odisha, according to the health minister. At the same time, Kerala, which was previously undecided, has agreed to launch the scheme, said Nadda on Monday. So far, around 12 states have signed agreements and deliberation is on with the rest, he added.

"There are states (signing the MoUs) that don't have their own health insurance. There are also some states doing MoUs that have their own health insurance and are still doing this (implementing AB-NHPM), which is why the MoUs signed are different for each state," said Nadda.

"Almost all states are on board," Dinesh Arora, Deputy CEO, Ayushman Bharat National Health Protection Mission, told ET. "We expect about 20 states to be fully signed up by the end of this week and 25 states by 30th of June," he added.

It is up to the states to decide whether they want to run the scheme alongside their own schemes or whether they want to integrate AB-NHPM into their existing health insurance policy, said the health minister. Some states are combining the schemes where the population to be covered is low and they can manage the difference, according to him.

The government is encouraging states to implement the scheme using the trust model, he added. Around 10 states and union territories are expected to implement the scheme through a trust model, while five may do so through a mixture of trust and insurance, according to data from the ministry.

The IT platforms to launch AB-NHPM will be in place by mid-July, according to Nadda. "All IT testing process is done. The moment we are confident that we are able to cater to 50 crore people, we will launch it (AB-NHPM)," he said.

Source

We will talk about health rather than health insurance: Mayank Bathwal, Aditya Birla Health Insurance - The Economic Times – 11th June 2018

Ayushman Bharat is a positive development as it will create massive awareness about health insurance among those who are still not covered, Mayank Bathwal, CEO Aditya Birla Health Insurance tells ET Wealth.

How has Aditya Birla Health Insurance differentiated itself from its peers?
There is clearly a need for health insurance as the penetration is low and the cost of healthcare is rising. Most people think group covers are sufficient, but this is misleading as it will not be there when they retire or quit their organisations. After speaking to customers, we realised that they felt health insurance was meeting a small part of their needs, that is, only hospitalisation claims. Therefore, we adopted a slightly different approach. We decided to talk about health rather than health insurance. We do have a vested interest because if something good happens, we will benefit as claims will be down. To draw a large part of Indian consumers who are 35 or younger and have largely stayed away from health insurance, but are taking care of their health or are generally healthy, we decided to incentivise them by offering 30% of the premium back every year. We track their physical activity and health behaviour, in addition to health assessment at the beginning of the year, at our own cost. This is possible because of technology—smartphones can be linked to our app to track active days. Secondly, even if you contract lifestyle diseases, we put you on a chronic care programme at no extra premium. A health coach is appointed and complements the doctor of the policyholder. We also have a cadre of care mangers who help you navigate the complex healthcare ecosystem in case of hospitalisation. In our first financial year, we have collected Rs 250 crore in premium and covered a million lives.

What will be Ayushman Bharat's impact on the healthcare and health insurance space?
I think it is a positive development. The big thing is that it will create massive awareness. We could not have created awareness on this scale. If I now go to prospective policyholders, at least they would have heard about health insurance. It will also bring in better healthcare infrastructure. You will see further investment on the healthcare side, which will help as we do face challenges around healthcare facilities in smaller towns. Also, a lot of data will be collected. Technology and the ability to leverage it will become critical to manage healthcare data effectively. Yes, there are some concerns around pricing, but to me, those are issues that will have to be tackled as we move ahead in the journey. We will have to start somewhere. Some healthcare providers are not happy with package rates and we will see how it goes.

Can it bring about some about some kind of standardisation in treatment costs? Will private health insurers benefit from it?
We have been talking about standard treatment protocols. This will be the beginning. Otherwise, how will you have package rates? They will work only if they are standard protocol-driven. The government is also talking about quality audits —what they are saying is that you can't under-treat a patient. So there will be package rates, quality accreditation and, over time, outcome-based framework. If the patient has to undergo treatment again, it could mean that there was a gap. If there is less repeat, then the healthcare units will be rewarded. From a design perspective, it is the right thing to do. In mature markets, this is what is happening. This is the way to control costs.

This system will act as a proxy regulator. There are going to be package rates, quality audits and fraud checks. Then there will be state disciplinary committees too. Insurers can give feedback on frauds and every tenth case can be investigated, for instance. The success depends on the execution, but I am happy that the design is being done right. At the moment, I am positive that it will be executed well.

What would be a healthy claim ratio for this programme?
Anything less than 100% would be healthy. There has to be money made, otherwise it will not be sustainable. Pricing will have to settle at a level where there is some money to made. We would like to explore the opportunity as for a new company like ours, it will give us scale which otherwise will take a long time to achieve.

What is the target customer group for your retail portfolio?
Our focus is not so much on income or age, but on the health intent. If you have it, you will find something in our offerings. If not, then you will not see value in the 30% health returns that you can earn. There is an element of cognitive segmentation of people with health intent. Our products are meant for all age groups, there is no upper limit on entry age. Our offerings are drawing younger policyholders. Our average customer age is less than 35 years.

Wellness is a key area of focus for you, but how do you quantify benefits?

We call up customers to remind them that their health assessment is due. There are rewards for customers who do it within 90 days. At present, 20% of our customers have started the healthy journey. We plan to take it to 30% and 50% over the next few years. We will track claims of people who have started their health journey and those who haven't. If we can prove that claims are lower for the former, then we know we are doing it right. It will take 18-24 months to give data, but this is how we will track the effectiveness of the wellness element.

Source

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Matters of the heart – The Indian Express – 11th June 2018

A recent Indian study on health outcomes of angioplasty, a procedure performed on heart patients, has shown that stenting all blockages in the heart can reduce survival and increase chances of death. The study covered 4,595 patients treated in a government insurance scheme over a four-year period. It highlights the need for closer observance of clinical protocols and calls for more caution in decision-making.

It also points to the need to collate data on clinical performance indicators at hospitals and also at state level, and to regularly provide such data to doctors so it could be used to improve survival and recovery rates of patients treated. Given that the recently announced Ayushman Bharat scheme is a major intervention in the healthcare market, the study suggests that patient outcome indicators need to be integrated with the functioning of the scheme, for it to truly reduce death and disease in the country.

In the study that has been published in international journal PLOS One in May, 4.5 per cent of patients died within one year of the procedure. These deaths were related to high numbers of stents implanted and to greater stent length. Greater age of patient was also directly related to death. The lead author of the study, Dr Bhanu Duggal, a cardiologist from AIIMS Rishikesh, suggests that only those blockages in the heart that are shown to be responsible for heart disease, should be stented, for better health outcomes.

Heart disease, according to 2016 data, is the leading cause of disability in India today and accounts for 28 per cent of all deaths in the country. Providing optimal and cost-effective care to patients, then, must be a serious concern for public policy.

Yet, the current discourse on public health is almost entirely dominated by financing issues rather than possible strategies to improve the health status of patients. No doubt it is important to provide financial support to needy patients. But, surely, it is even more important to see that the maximum number of patients treated recover fully. The only way to ensure that healthcare becomes more patient-centric is if research studies come out of rarefied clinical discourse into public spaces.

These findings suggest two things. One, that better decision-making can improve chances of patient survival in angioplasty cases. Ideally, a cardiac surgeon should also be involved in the treatment decision and not just cardiologists alone. Today there are no norms of this kind in India.

The second implication of the study is that better decision-making can cut costs significantly. After all, given the high cost of stents, the issue of appropriate use becomes critical. Moreover, heart procedures constitute a very large percentage in monetary terms, of monies allocated in public insurance schemes.

The Indian healthcare scenario is characterised by the relative absence of appropriate use criteria for surgical procedures. Appropriate use criteria mean that in any health care scheme, before proceeding for a surgery, the doctors concerned affirm that the case in question conforms to pre-defined norms. The norms are hard-wired into the scheme. So in the case of angioplasty, the use of such criteria would mean that for all elective procedures, the physicians would need to state explicitly on paper that only those blockages that are shown to be responsible for heart disease are proposed to be treated.

Currently, to our knowledge, there is only one health scheme in India, namely the Maharashtra health insurance scheme, that funds secondary and tertiary care, that formally links appropriate use criteria to incurring expenditure in the scheme. The Maharashtra scheme requires treating physicians to fill out a form designed by the topmost experts in the field for each clinical indication that is being treated. Only after that is permission given to proceed. In case of any difference of opinion, the physician is required to record his reasons.

Another study, by Dr G Karthikeyan, cardiologist at AIIMS New Delhi and lead author, showed that in one year after the introduction of these criteria in the Maharashtra scheme, the incidence of angioplasty as a proportion of

all treatments, was reduced by 12.3 per cent. Given that angioplasty accounted for roughly Rs 90 crore annual expenditure at the time and a major share of all claims, this was a significant saving. Interestingly, both studies show no difference in outcomes between public and private sector hospitals.

For nearly a hundred years now, Western countries have developed a convention of patient registries. Such a register is specific for a disease and means that participating hospitals record patient information in the register. The information, recorded over time, can provide extremely valuable inputs for improving treatment protocols. In the US, using data from the National Cardiovascular Data Registry, a study of over 5,00,000 patients who had undergone angioplasty between 2009-2010 showed that while interventions in emergency situations were appropriate, for elective procedures, only 50 per cent could be categorised as appropriate, 38 per cent were uncertain and 12 per cent were inappropriate.

In India we have no such convention, nor are hospitals required to collate procedure specific data. The government has great market power in the health space today. Such market power could conceivably be used to improve the practice of medicine. We have any number of highly qualified doctors who are willing to help and who have devised appropriate use criteria. If only such criteria could be structured into group insurance schemes, they could do a great deal of good. In a knowledge society, the use of evidence-based criteria can save many lives.

Source

Back

Ayushman Bharat: States may combine their health cover schemes with centre's - The Economic Times – 11th June 2018

States such as Gujarat, Himachal Pradesh, Assam, Tamil Nadu and Andhra Pradesh may combine their existing health insurance programmes with the prime minister's ambitious scheme to provide health coverage to 100 million poor families.

The move is expected to expand coverage under the existing state health schemes, according to Ayushman Bharat National Health Protection Mission (ABNHPM) CEO Indu Bhushan. Gujarat, Tamil Nadu and Andhra Pradesh are expected to sign memoranda of understanding (MoUs) with the Centre to this effect this month. Himachal Pradesh and Assam signed such agreements in May, he said. The merging would happen in a way that key features of both schemes will be retained, according to him.

"A large number of states have their own schemes covering more than the number of beneficiaries we are proposing," he told ET in an interview. "In those cases, we are asking the states to combine the two schemes, taking the key features of ABNHPM like coverage for Rs 5 lakh, national portability, unified IT framework and coverage of all SECC (Socio-Economic and Caste Census) eligible beneficiaries."

MoUs TO LIST OBLIGATIONS, TIMELINES

Combining two schemes will provide greater coverage because, even if some states have health insurance schemes, none of them offer as much as Rs 5 lakh coverage so far, he said. A merger will allow patients to avail the scheme's benefits in different states through the national portability feature and may also expand the number of treatment packages in some of states currently offering 700-800 treatments, he added.

In case the package rates offered under existing schemes are higher than the ABNHPM rates, states are at liberty to revise the Centre's proposed rates to match their own, Bhushan said. Rajasthan, Himachal Pradesh, Tamil Nadu, Kerala, Andhra Pradesh, Karnataka and Assam have their own health schemes.

Tamil Nadu is waiting for formal approval to combine its own comprehensive health insurance scheme with ABNHPM, but will "hopefully" sign an agreement this week along with Gujarat, which is ready with its MoU, said Bhushan. "Andhra Pradesh has a trust already. For them, it is a question of increasing coverage to Rs 5 lakh, expanding treatment packages and including national portability." Madhya Pradesh, Uttar Pradesh, Bihar, Jharkhand and Chhattisgarh, which don't have their own state schemes, are expected to sign agreements this week after finalising if they will implement ABNHPM through a private insurance or trust mode, he said.

The MoUs will also list the obligations of the Centre and the states and the timelines to be followed to ensure states are prepared for an August 15 rollout of the scheme. So far, 10 states and union territories without their own health protection schemes have already signed such MoUs, he told ET. A third of the states and UTs have settled on a trust model to implement ABNHPM, including Bihar, which was earlier considering the private insurance route, according to Bhushan.

"Many state-sponsored health insurance schemes are already covering extensive range of packages proposed under Ayushman Bharat with family coverage of Rs 1-1.5 lakh. The increased coverage to Rs 5 lakh per family per year is mainly to attract high-end corporate hospitals into the scheme," said Indranil Mukhopadhyay, associate professor at OP Jindal Global University School of Government and Public Policy. "However, it is highly unlikely that in one family, there would be more than one person needing high expenditure packages in the same year."

Source

According to him, a more significant contribution of the Ayushman Bharat programme is its health and wellness centres, which seek to provide access to medicines and diagnosis at the grassroots level. Current allocation to these centres is meagre and needs to be significantly increased, he said.

Back

Crop Insurance

Pradhan Mantri Fasal Bima Yojana: Premiums move up after Centre's nudge – Financial Express - 14th June 2018

The Pradhan Mantri Fasal Bima Yojana (PMFBY) may have faltered after a promising start, but insurance companies seem to renew their interest in the NDA government's flagship crop insurance scheme. Thanks to constant prodding by the Centre, several state governments that had developed cold feet in paying their shares of premiums in time are now contributing. If the trend is sustained, claims-to-payout ratio under PMFBY could improve, leading to its wider coverage and remunerative margins for the insurers.

In Kharif 2017, 23 states — for which date is available — paid a premium of Rs 4,148 crore, more than three-fourths of their share. The gross premium collected for the season was a little over Rs 19,000 crore — farmers pay only a fifth of the premium, while the Centre and states foot the balance bill. As for the latest rabi season (17-18), while the states' premium share is estimated at Rs 1,607 crore, states have already contributed Rs 579 crore.

Maharashtra (`1,070 crore), Karnataka (`614 crore), Odisha (`278 crore), Uttar Pradesh (`240 crore), Haryana (`109 crore) and Chhattisgarh (`93 crore) have paid close to 100% of their share of premium in Kharif 2017. Madhya Pradesh (`694 crore) and Rajasthan (`364 crore) too have paid a substantial part of their premiums. Among the laggards were Andhra Pradesh, Telangana and Bihar, which have contributed zilch.

The ratio of claims made to the payout was close to 100% in Kharif 2016 and above 93% in Rabi 2016-17 as well. The ratio has subsequently slipped to very low levels primarily due to the states' reluctance/ inability to pay, but an uptick has been seen lately. About 42% if the claimed made by the farmers were paid by the insurers in Kharif 2017, according to data reviewed by FE.

Even though PMFBY is looking up, its targets are still daunting. The Modi government had said 50% of the country's gross cropped area would be insured by the end of the current financial year from 30% now; only Madhya Pradesh is around the target now, while in case of many states, the coverage is still far below the target.

Analysts say that the claims ratio — claims made to the premium charged — needs to improve a lot for the scheme to be viable. Insurers such as ICICI Lombard, Tata AIG, Cholamandalam MS, HDFC ERGO, Bajaj Allianz and Universal Sompo are yet to settle claims worth over Rs 3,800 crore to farmers since 2016-17.

Source

The unpaid premium by the states stands at Rs 2,490 crore now. Since the start of the scheme, Rs 12,259 crore have been paid to farmers by some 15 insurers (for which data are available), out of the claims of Rs 16,061 crore.

Back

Bihar opts out of PM's crop plan - The Tribune – 11th June 2018

The Bihar Government on Monday decided to start its own crop insurance scheme for farmers, opting out of PM Narendra Modi's ambitious crop insurance scheme that was launched in 2016.

After a public meeting at his residential office, CM Nitish Kumar said farmers who had taken loan were not benefitting fully from the PM's crop insurance scheme. "The Centre and the state are equally paying premium to insurance companies and a little sum is also being paid by farmers in the PM's crop insurance scheme. In spite of

that, insured money to farmers is getting delayed and what they are getting is less than the premium state government is paying," he said.

He said the state had decided to offer them its own crop insurance scheme wherein they wouldn't pay any premium. As per farmers' requirement, the state scheme has crafted the scheme to assist them against pre-sowing and post-harvest hazards.

Source

Back

Reinsurance

GIC offer for sale likely in second half of this fiscal – Financial Express – 14th June 2018

The Centre is mulling an offer for sale (OFS) in the General Insurance Corporation (GIC) during the second half of 2018-19, a year after its listing. The timing of the OFS, however, would be decided after the stock recoups its recent losses, officials said.

The government listed GIC Re, India's biggest reinsurer, in October last year. The Centre had sold a 12.5% stake to mop up Rs 9,704 crore in disinvestment revenue, while the company issued fresh shares to raise Rs 1,553 crore to fund business expansion.

However, the stock has since been trading below its issue price. It is now trading close to 20% lower than the issue price of Rs 912. A 10% stake sale in the firm would fetch about Rs 6,400 crore at current market prices, about Rs 1,500 crore less than what it would have raised had prices not crashed since the IPO.

Global catastrophes and high claims in the Pradhan Mantri Fasal Bima Yojana (PMFBY) has hit the company, with the overall claims ratio rising from 81% in FY17 to 86.5% in FY18. Its FY18 net profit was `3,234 crore, up only 3% year-on-year, against a 10% growth reported in FY17. GIC's PMFBY portfolio had a combined ratio of 107% in the past two years. The combined ratio, a measure of insurance company's profitability expressed as total cost to total revenue, above 100% indicates losses.

GIC provides reinsurance across fire, marine, motor, engineering, agriculture, aviation, health, liability, credit and financial and life insurance. According to CRISIL Research, the company accounts approximately 60% of premiums ceded by Indian insurers to reinsurers in FY17.

Despite the volatility in the stock, officials see potential in the company as it will continue to retain its dominant position in the domestic market. According to current regulations, Indian insurers seeking reinsurance cover for their risks would have to give first preference to GIC Re.

While the Centre managed to mop up a whopping Rs 1 lakh crore from disinvestment in FY18, the target of `80,000 crore for this fiscal year is challenging, as the pipeline is modest and the markets have become volatile. Besides, the privatisation bid of the Air India-Air India Express (AI-AIE) combine has failed to take-off as no bidder showed interest.

Source

Back

India: Regulator to allow reinsurers to invest abroad – Asia Insurance Review

The Indian insurance regulator, IRDAI, will allow reinsurance companies to invest outside India so as to diversify investment portfolio risk, and to promote the country as a major reinsurance hub.

"The insurance regulator is working on relaxing investment norms for reinsurance companies, allowing them to invest outside India to diversify their risks," a source close to the development told *The Economic Times*.

"The IRDAI is likely to allow these companies to invest in sovereign debt of other countries with A and above rating. IRDAI is studying the regulations of other countries."

State-run locally incorporated GIC Re manages assets worth about INR1,100 billion ($16.3 billion), while foreign reinsurance companies that have set up shop in India are increasing their funds. Foreign reinsurers have to invest 50% of the premium earned in India in the country.

Foreign reinsurance companies were allowed to open branches in India in 2015. At present, there are eight foreign reinsurance companies operating through branches in India.

Source

Insurance Cases

Insurance firm asked to pay Rs 2.15 lakh - The Tribune - 10th June 2018

The district consumer disputes redressal forum has directed an insurance company to pay Rs 2.15 lakh along with interest to the owner of a stolen vehicle besides Rs 5,000 as litigation expenses. Raja Iqbal Singh, a resident of Rani Ka Bagh, had filed a complaint against Iffco Tokio General Insurance stating that he had got his second hand car insured from the opposite party for the sum assured Rs 2,15,180.

He stated that during the validity of the insurance, the car was stolen from outside a gymnasium. An FIR was registered and the insurance company was intimated. He stated that all the documents along with the key as demanded by the company were submitted but the company denied the claim.

The claim was denied as the firm claimed that complainant hadn't supplied original police report as well as the original purchase invoice. He stated that as he had purchased the second hand car, and the original purchase invoice was not available. He maintained that the police report was supplied immediately after its issuance by the court.

The opposite party, in its reply, stated that they were informed about the theft a day after the theft. The reply stated that the complainant had handed over two forged keys of the said car to the investigator. "When the investigator enquired about the original keys, the complainant said that he didn't have that. The act of providing forged keys of the stolen vehicle is a clear case of misrepresentation and is a violation of conditions," stated the reply.

The forum observed that the stand taken by the opposite party is not based upon any evidence as the keys which were available with the complainant were duly supplied to the surveyor and the opposite party has taken this plea only to repudiate the genuine claim of the complainant.

Source

Back

Pensions

EPFO directs offices to pay higher pension to eligible EPS members - The Economic Times – 14th June 2018

There is some good news for Employees' Pension Scheme (EPS) subscribers after a rather long wait. Those EPS members eligible for higher pension, post a Supreme Court judgement, but were being turned away by provident fund offices can now get their dues thanks a recent circular by the Employees' Provident Fund Organisation (EPFO).

The EPFO has started pushing its offices to give higher pension to those EPF members who are eligible for it based on a landmark judgement by the Supreme Court in October 2016. The apex court's judgement had directed the EPFO to revise the pension on higher wages of the petitioners under EPS.

However, it seems some field offices are yet to implement the same and have been delaying the process in the garb of non-availability of explicit instructions from the EPFO head office.

EPFO head office has taken this matter seriously and on June 8, 2018 it issued a circular stating, "No instructions can be kept aside for compliance only on the ground that reference has been made to Head Office for further clarification on assumption basis without attempting to comply those instructions practically.

EPFO circular goes on to say - "Many field offices are taking appropriate actions on the detailed order of the Supreme Court duly circulated by Head Office for compliance by utilizing t he provisions already existing in the relevant software, whereas some offices are deliberately not taking any action to revise the pension claims to eligible members by taking one plea or the other." For the year ending 31st March 2018, based on the number of cases received by them, these were the regional offices which have revised the pension.

The circular rests the liability on the regional provident fund commissioner (RPFC) if eligible cases get delayed. "The number of grievances due to non-settlement of eligible cases is rising and it is made clear that the concerned RPFC will be held responsible for denial / delay in settlement of such cases to eligible applicants. If any applicant is found not eligible for revision of pension as per the Supreme Court order, the same must be conveyed to the applicant within seven days of receipt of such request," it stated.

No. of cases revised for higher wages for the year ending 31st March 2018					
Regional office	No. Of pensioners	Amt. of contribution and interest remitted by pensioners (Rs)	Old pension(Rs)	New pension (Rs)	Pension arrears paid to pensioners (Rs)
Kannur	183	338821	337419	1148500	47534174
Kochi	567	182526758	1043778	4602709	191138600
Kollam	104	43545566	180086	987163	51771539
Kottayam	69	26717760	128778	624129	27067764
Kozhikode	931	185579607	1977712	5838795	223848112
Trivandrum	1048	309607372	1903936	7796120	379563155
Coimbatore	3	1223888	6457	26642	562261
Chandigarh	19	10760076	34373	211428	1186290
Shimla	307	103484413	640179	2520034	100761400
Bhatinda	1	704682	1816	9750	780047
Bhopal	9	2266369	15876	34201	1637433
Indore	10	3286217	17976	73850	2229865
Hubli	1	17577	2335	7002	158058
Guntur	295	77572487	550624	1851806	93120606
Jabalpur	23	4685100	48856	173488	7626301
Total	3570	985859986	6890201	25905617	1139662216
Source: EPFO website					

Following the Supreme Court, it was expected that eligible EPS members could soon approach the EPFO to retrospectively enhance their contributions on higher wages in order to get a quantum jump in their pensions.

To do this, the eligible member would have to submit an application on a plain paper to the PF office mentioning their retirement date and other pension details. The PF office would then recalculate the revised pension. Obviously, those pensioners who had withdrawn their entire EPF would have to put back some funds into it for the above process to be effected.

In June 2017, EPFO circulated an internal circular to their regional offices asking them to keep a track of the pensioners whose pension pay orders (PPO) have been revised. "All offices are also required to forward a monthly return with respect to the payments made to pensioners on the actual (higher wages)", in a specific format, that circular stated.

The background

In March 1996, the EPS Act was amended to allow members to raise their pension contribution to 8.33 percent of full salary (basic + dearness allowance) irrespective of what the salary is. However, for a decade not many people opted for higher contribution.

In 2005, following media reports, including Times of India, several private EPF trustees and employees approached EPFO with the demand to remove the ceiling on their EPS contributions and raise it to their total salary. The EPFO rejected the demand claiming that their response should have come within six months of the 1996 amendment. In October 2016 Supreme Court ruled in favour of employees' right to raise their contributions to the pension fund without imposing any cut-off date for eligibility.

In September 2014, the pensionable salary limit was raised from Rs 6,500 to Rs 15,000, and existing employees who were contributing on full salary were asked to furnish a fresh option within 6-12 months. Simultaneously, EPFO stopped contributions on full salary from thereon.

In order to comply with the SC orders, in March 2017, the EPFO came out with a circular allowing member of EPS who had contributed on higher wages exceeding Rs 6,500 to divert 8.33 percent of salary exceeding Rs 6,500 to the pension fund, and subsequently be eligible for pension on higher salary.

What you should do

Going by the recent circular (June 8), it seems like the process will be easier and much smoother for eligible members. The details required to be considered are member's name, date of retirement, amount of contribution and the interest to be paid back by the member, old and the new pension, and pension arrears to be paid by the pensioner. So, if you are an eligible member, approach your nearest PF office and cite the latest EPFO circular to them.

Source

Back

Atal Pension Yojana: Govt mulls hiking pension limit to up to Rs 10,000/month - The Hindu Business Line – 12th June 2018

The government is considering a proposal to raise the pension limit under Atal Pension Yojana (APY) to up to Rs 10,000 per month from the existing slab of up to Rs 5,000, a top official said today.

There is a need to increase the value of pension under APY, Madnesh Kumar Mishra, Joint Secretary, Department of Financial Services (DFS), said at a conference organised by PFRDA.

"We have seen the proposal (sent by PFRDA) of increasing the pension value to (up to) Rs 10,000 per month and it is under our active examination," Mishra said on the sidelines of the event.

Pension Fund Regulatory and Development Authority (PFRDA) Chairman Hemant G Contractor said the proposal has been sent to the Finance Ministry with an aim to increase the subscriber base of APY.

"Currently, we have five slabs of pension from Rs 1,000-5000 per month. There has been a lot of feedback from the market asking for higher pension amounts because many feel that Rs 5,000 at the age of 60 years, 20-30 years from now, will not be sufficient.

"We have placed this proposal with the government that it should be increased to up to Rs 10,000," Contractor said.

PFRDA has sent two more proposals to the ministry - auto enrolment for APY and raising the maximum age bar to enter the scheme to up to 50 years.

Currently, the age of entering APY is from 18-40 years but an increase in the same by another 10 years- from 18-50 years - will help in expanding the subscriber base, he added. The subscriber base of APY is 1.02 crore.

Source

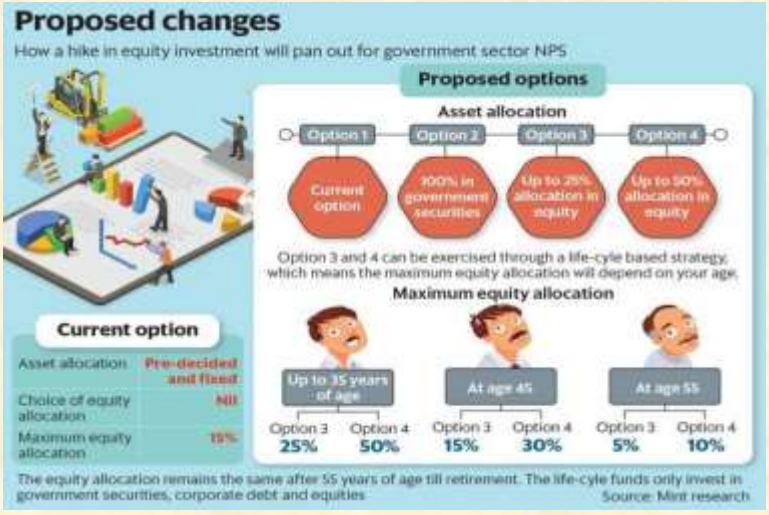
PFRDA added about 50 lakh new subscribers under the scheme in 2017-18 and hopes to add another 60-70 lakh in the ongoing financial year, Contractor said.

Back

Government employees may have to wait more for hike in NPS equity limit – Mint – 11th June 2018

The Pension Fund Regulatory and Development Authority (PFRDA) is hopeful that the government will allow a hike in the equity investment limit for government sector National Pension System (NPS) from 15% to 50%. For this, PFRDA has proposed an action plan. PFRDA has proposed hiking the equity investment by allowing life-cycle funds.

However, this may not happen anytime soon as PFRDA is still awaiting a formal notification from the government. "NPS for the government sector was designed by the government so it's up to the government to increase the equity limit. The government is yet to think seriously about it,"said Kumar Sharadindu, managing director and chief executive officer, SBI Pension Funds Pvt. Ltd.



Government NPS

The genesis for a hike in equity allocation even for government sector employees is in the recommendation of the G.N. Bajpai Committee report that seeks to harmonise investment guidelines for government and private sector NPS. While the equity investment limit for the private sector has already been hiked to 75%, there is no word on hike in the equity limit for government employees to 50% yet. Central government employees (except armed forces) who joined services from 2004 are part of the NPS; even employees of most state governments are in it.

Unlike private NPS where subscribers can choose the fund managers and the funds, government NPS offers no choices for either. The money is invested in a pre-decided proportion across three state-run fund managers—SBI Pension Funds Pvt. Ltd, UTI Retirement Solutions Ltd and LIC Pension Fund Ltd—and the caps in each asset class are clearly defined. According to rules, each of the pension fund managers can invest up to 50% in government securities, up to 45% in debt instruments, up to 5% in short-term debt instruments, up to 15% in equities and up to 5% in structured securities and other miscellaneous investments.

What could change

Things will change if the government gives its nod to hike the equity investment limit.

Choice of funds: According to a PFRDA official who didn't want to be named, government employees may get three more options, in addition to the existing option, which will be the default option.

The first will allow subscribers to invest 100% of their funds in government securities. The second and third options will allow for equity exposure through passive or life-cycle funds (see graph).

At present, under private NPS, subscribers who are confused about their asset allocation are offered three life-cycle funds that take exposure to equities depending upon their risk appetite and years left to maturity—conservative, moderate and aggressive. The government sector NPS will allow a hike in equity investments by allowing subscribers to invest in equities either through conservative or moderate life-cycle strategy.

The conservative life-cycle plan under private NPS is meant for risk-averse investors, as the maximum allocation to equity is 25% till 35 years of age. After that the equity allocation begins to taper and by the time the investor is 55 years of age, the equity allocation is only 5%.

The moderate life-cycle fund starts with a 50% allocation to equity till 35 years of age and tapers it to 10% by age 55. The aggressive life-cycle fund starts with equity allocation of 75% till 35 years of age and tapers it to 15% by age 55.

A life-cycle based approach not only optimises returns but also cushions you from market volatility as you approach maturity.

Choice of fund managers: In addition to offering the employees the choice of funds, what is also on the cards is allowing private sector pension fund managers to manage the government corpus and also to allow employees the option to choose their fund managers.

As on 30 April, the subscriber base of government sector NPS was around 58 lakh with assets under management (AUM) of around Rs 2.03 trillion, the subscriber base for private sector was around 14 lakh with an AUM of Rs 27,982 crore.

Source

Allowing private fund managers to manage the government corpus will not only increase the choice for subscribers and aid market competition, but will also help fund managers sustain a low-cost model. While the action plan may be in place, a government approval is needed. This means the wait is not over yet.

Back

Survey & Reports

31% senior citizens willing to use health insurance app: Survey - The Economic Times – 11th June 2018

31% : respondents in the 51-55 year age group are willing to download the health insurance app.

40% : respondents willing to do so are from Hyderabad, the highest in the country.

Exercise and balanced diet

64%: in the 51-55 year age group think exercising is important for health
68%: believe having a balanced diet is equally important

Financial stability

20%: respondents in the 51-55 year age group believe financial stability impacts general wellness.
19%: respondents in the 28-30 year age group think so.

Wearables like fitness bands

29%: of 51-55 year olds believe wearables such as fitness bands are important for wellness
32%: respondents in the 28-30 year age group think so.

Health checks

Source

42%: respondents in the 51-55 year age band believe preventive health checks are important for good health.
34%: respondents in the 28-30 year age band regard the same as important.

Indian cities least resilient to risk: Lloyd's – The Times of India – 10th June 2018

Economies of Indian cities are least resilient to crises and stand to lose the biggest chunk of their gross domestic product (GDP) in the event of natural disasters or civil conflicts. According to a report by insurance marketplace Lloyd's of London, Delhi has the highest GDP risk followed by Mumbai and Bangalore.

The 'City Risk Index' is a report aimed at helping policymakers, businesses and societies understand the financial impact of risk in their cities as a first step of building resilience. It measures resilience against 22 threats, which include risks relating to civil conflict, terrorism, natural catastrophes, market crashes and technology.

The study covers 279 cities, including 92 in Asia. Incidentally, three Indian cities — Delhi, Mumbai and Bengaluru — and one Pakistani city, Karachi, are in the index's top 10 global cities that could face terrorism. Delhi, Mumbai and Karachi are in the top 10 at risk for civil conflicts. Thailand, with a high dependence on tourism, stands to lose the most due to a terrorist event, while Shanghai tops the global charts for human pandemic. Japanese cities are mostly at risk due to natural disasters and cyber threats. According to the study, if all the 19 cities ranked 'weak' in terms of resilience were to move into the 'strong' category, the continent would save $34 billion.

According to Lloyd's of London country head and CEO (India) Shankar Garigiparthy, anything that happens around Delhi's borders has a bigger impact than before as boundaries of the National Capital Region (NCR) have been redrawn, and include Haryana and UP. "In Mumbai, too, civil conflict is the number one threat. But, interestingly, flood is lower down the risk because the city is slightly better prepared and has learnt from experience," said Gargiparthy.

Source

Lloyd's, headquartered in the UK, has received permission to set up operations in India. Although Lloyd's by itself does not undertake insurance business, it acts as a marketplace and allows global reinsurers to do business.

Back

Opinion

How built-in safeguards in insurance help – Mint – 14th June 2018

Opinion given by Kapil Mehta is co-founder, Securenow. In

About seven years ago, a 65-year-old gentleman visited me. After paying premium for eight years, he had been informed that his medical insurance would not be renewed. Despite having read the contract, he missed noticing the clause that restricted the maximum age to 65. Now, given his worsening hypertension, the man feared that no insurer would cover him.

There are two distinct approaches to writing laws for financial products. The democratic way is to put out detailed disclosures and then leave customers to make their choices. The other, more authoritarian, route is to build safeguards into the law such that even if a financially illiterate person (an overwhelming majority) were to buy the insurance, they would be okay. Any law is a mix of these two approaches. But most often I see the mandatory safeguards are more effective than disclosures.

Health insurance has some excellent safeguards. All health covers now must be renewable lifelong. The gentleman I wrote about, now 72, would still have had his original health insurance if this legislation had come in earlier. The law also stipulates that the premium you pay should be in line with the entire class of people your age. Insurers are not allowed to charge you a different rate just because you have made a claim. These two features, put together, make it imperative that you buy insurance early on, when you are healthy, and then hold on to it for life.

The law, in 2013, standardised the definitions of several exclusions and diseases. All insurers now follow these defined terms such as pre-existing diseases, cancer, room rent and hospitals. Previously, for example, pre-existing diseases were interpreted in many ways. Some said that the policyholder should have been aware of the disease, others that awareness was not necessary; the time of pre-existing symptoms also varied widely. With the current safeguard, even if you do not read the contract, a minimum standard will be adhered to.

The law now excludes health insurance from the principle of contribution. This contribution clause stipulates that if you have multiple insurances then each insurer must pay their proportionate share of a claim. This

sometimes led to delayed payments and disputes. For example, one insurer would accept the claim and the other might reject. Or in cases of cashless claims, there would be disputes about which insurer should pay first and up to what limit. Today, you can decide which insurer to approach and they will have to pay the entire amount, subject to their insurance's sum assured limits.

Previously, claims had to be submitted within a certain number of days, typically 30 to 60. The restriction still holds but regulations ask insurers to condone delays if there is a reasonable cause. Life insurance also has many safeguards. The only exclusion allowed is suicide in the first policy year. Claims cannot be repudiated after the insurance has been in force for three years. These conditions effectively shift the responsibility of identifying issues of misrepresentation or non-disclosure to the insurer and set a time limit for such discovery.

In unit-liked insurance plans (Ulips), the yield reduction allowed is capped. In these products, you decide which assets to invest in. The yield-reduction cap limits the charges in your insurance and assures that the returns you get are in line with the underlying assets. An insurer cannot pay excessive commissions or charge you high fees because that will breach the reduction in yield allowed. Another excellent safeguard is that there cannot be a surrender charge if you close your insurance after five years. This benefit goes together with the restriction that you cannot withdraw money in the first five years. So, the law forces you to take at least a five-year outlook when you invest in a Ulip.

Life and health insurance allow a free-look period of 15 to 30 days to return your insurance, if not satisfied. Similarly, a 30-day renewal grace period is in-built so that you don't lose continuity benefits if you miss renewal but pay within 30 days of the due date.

There are some areas where safeguards can be improved. Traditional participating endowments, the largest selling life insurance, should have limits on charges and surrender costs similar to Ulips. Some definitions need to be clarified. For example, exclusions due to substance abuse should be made more specific. The difference between external and internal congenital diseases causes confusion. The concepts of free-look period and 30-day grace period should be extended to more individual insurances such as property and liability. There is a silver lining to the story about the man who lost his insurance at 65. The market has developed so much over the past few years that he has been able to buy, even with his hypertension, a new and better insurance with a higher sum assured. This time, all the safeguards have been automatically built in.

Source

Back

IRDAI Circular

Source

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

Source

First Year Premium of Life Insurers for the Period ended 31st May, 2018 is available on IRDAI website.

Source

List of Licensed Insurance Brokers As on 5th June, 2018 is available on IRDAI website.

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Global News

Thailand: Insurance premiums to breach THB1-trln mark by 2020 – Asia Insurance Review

Insurance premiums are expected to break the THB1 trillion ($31.1 billion) mark for the first time in one or two years' time, supported by Thailand's GDP growth, the positive trend in the life assurance business, and growing bancassurance distribution channels for both life and non-life products, according to Mr Chuchatr Pramoolpol, deputy secretary general of the OIC.

The THB1-trillion mark is within reach. Total insurance premiums in Thailand for this year are projected at THB871 billion ($27.1 billion), an increase of more than 6% from last year, reports *The Bangkok Post* citing Mr Suthiphon Thaveechaiyagarn, secretary general of the Office of the Insurance Commission (OIC). Of this, life premiums are forecast at THB640 billion and non-life premiums at THB231 billion. For the first quarter this

year, total insurance premiums reached THB216 billion, up by 5.9% year-on-year, and accounting for 5.32% of the country's GDP. Life assurance premiums stood at THB159 billion and non-life premiums at THB57 billion.

"The interesting point for life assurance is how unit-linked products posted drastic growth of 264% year-on-year to THB9.13 billion in the first quarter, and premiums from insurance riders to health insurance contracts accelerated by 11.8% year-on-year, valued at THB19.1 billion, reflecting growing health concerns among consumers," said Mr Chuchatr.

Source

Back

China: Insurers show stable solvency position in aggregate – Asia Insurance Review

The solvency ratio of China's insurance sector remained stable in the first quarter of the year, with risks generally under control, the China Banking and Insurance Regulatory Commission has said. The average solvency ratio of 173 insurance companies stood at 248% at the end of 1Q2018, and that of core assets at 237%, reports the Xinhua news agency citing the Commision.

The risks facing the insurance sector are generally controllable, but the situation remains complicated, the Commission said in a statement.Companies with high risk of liquidity will be instructed to improve their risk controls.

Source

Back

China: Regulator issues revised rules for actuarial functions – Asia Insurance Review

China's banking and insurance regulator yesterday issued revised rules that tighten actuarial reporting standards for life insurance firms, part of efforts to improve supervision and risk control in the country's financial sector, reports Reuters. The new rules require life insurance firms to tighten management of their liabilities, create a reporting system to cover asset and liability terms that facilitate linkage between the two and strengthen cash flow.

In recent years, a score of Chinese insurers have invested in long-term projects, funded by issuing high-yield, short-term universal life insurance. The regulator has expressed concern that the sudden withdrawal of funds from such short-term universal life products could have an impact on insurer cash flow. The rules also tighten the standards for hiring of chief actuaries, professionals who assess the probabilities of an event occurring among other things, on whose calculations insurance pricing is determined.

Source

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Indonesia: Takaful shows strong performance in 1Q – Asia Insurance Review

Indonesia's shariah insurance industry has recorded a positive performance in the first quarter of this year, as reflected by growth in takaful contributions. The Financial Services Authority (OJK) noted that for the first quarter of this year, takaful raked in contributions totalling IDR4.09 trillion ($293 million). This represented growth of 34.9% from the corresponding quarter last year, reports *Kontan*.

According to the chairman of the Association of Indonesian Shariah Insurance (AASI) Ahmad Sya'roni, the increase in contributions was due to more players entering the market, indicating that the potential of Islamic insurance was not optimised previously. In terms of penetration, the market share of shariah insurance is around of 5%. In 1Q2018, family takaful commanded contributions totaling IDR3.37 trillion while general shariah insurance posted contributions of IDR512 billion. Re-takaful contributions totalled IDR204 billion.

Source

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