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QUOTE OF THE WEEK

"Ultimately, education in its real sense is the pursuit of truth. It is an endless journey through knowledge and enlightenment."

- A. P. J. Abdul Kalam

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Participating and non-participating policies

Insurance policies that have a saving component to them (endowment or money-back plans) are of two types — participating and non-participating. In participating plans (also called with-profit plans), policyholders get a share of the company's profits, provided the company makes profit and declares bonus. Participating plans give a benefit illustration in the policy brochure, with gross return of 4 per cent and 8 per cent and show the maturity value. But beware! Don't take them at face value. The exercise is only for illustrative purposes. There is no way of knowing the returns beforehand as the returns depend on the bonus.

In non-participating plans (also called non-par or without-profit plans), policyholders don't get to share profits of the insurer. But returns are guaranteed upfront by way of additions to the cover under the policy.

So, the policyholder knows his returns at the time of signing up for the policy without any complex calculation. Most non-par policies in the market today give a return of 4-5 per cent.

Source

INSURANCE INDUSTRY

Insurers seek alternative to Aadhaar e-KYC as instant policies get delayed - The Hindu Business Line – 12th February 2019

Insurance companies are trying to work out alternative solutions to Aadhaar-based e-KYC authentication as instant policy approvals and some POS products have had to take a backseat.

Fintech innovations for the sector are being reworked or stopped, and insurers are now either using document-based verification or one-time passwords for online policies, along with scanned documents.

Following the Supreme Court ruling on Aadhaar in September, and new guidelines by UIDAI, the Insurance Regulatory and Development Authority of India (IRDAI) has asked insurers not to seek Aadhaar and PAN or Form 60 from the proposer and policyholder as part of KYC.

In a recent circular, the IRDAI had said that an insurance company can accept Aadhaar card as one of the documents for proof of identity or address of the policyholder for KYC if the person voluntarily gives it. "This includes physical copy of e-Aadhaar, masked Aadhaar and offline Aadhaar XML. However, insurers will, under no circumstance, do the authentication using e-KYC facility or Yes/No authentication facility of UlDAl," IRDAI had said.

Masking numbers

It has also stressed that insurers must ensure that the first eight digits of the Aadhaar number are properly masked, and that they do not store the last four digits in physical or digital forms.

Insurers say that they have already reverted to a physical or paper verification of the customer and, as such, there are no alternatives at present. Further, innovations in fintech that were expected to use e-KYC will now also have to be re-worked.

"The IRDAI guidelines are helpful and provide clarity. However, now physical verification has to be done," said Tarun Chugh, Managing Director and CEO, Bajaj Allianz Life Insurance. "The impact on insurers has been high. Aadhaar is now voluntary and there is a provision of masking. In any case, it is not e-KYC and no instant authentication can be done," said an executive with another insurance company, adding that even the use of a QR code would require a set of basic documentary proof from the customer.

A number of banks have also stopped or are re-working their instant account opening facility after Aadhaar-based e-KYC authentication was stopped. Fintech companies are still in discussions with the Reserve Bank of India on alternatives to Aadhaar-based e-KYC authentication, as they believe that paperwork is time consuming and expensive.

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Source

IRDAI REGULATION

IRDAI panel recommends regulatory sandbox for tech-based innovations - The Hindu Business Line – 11th February 2019

The Insurance Regulatory and Development Authority of India (IRDAI) will allow companies to test products as part of its regulatory sandbox approach to test new digital and tech-based innovations before launching them in the market.

A committee, set up by the IRDAI on regulatory sandbox in the insurance sector, has submitted its final recommendations.

It suggested the setting up of a core sandbox committee with dedicated personnel to monitor and supervise the digital innovations, and also facilitate the roll-out of experiments and to provide the ecosystem required for the experimentation.

Main categories

It has said applicants can test products for up to a period of one year in five categories – insurance solicitation or distribution, insurance products, underwriting, policy and claims servicing. "The permission shall be granted for a period of six months, which can be extended for another six months. In no case can the proposal be allowed to go beyond 12 months," said the report.

However, if the proposal covers 5,000 persons or completes Rs50 lakh of premium or any other parameter specified by the IRDAI, the proposal will be considered completed.

"Applicants would include insurers or insurance intermediaries or any other entity other than an individual having a minimum net worth of Rs25 lakh for the last three years," said the report, adding that if the category involves insurance product or underwriting, then the applicant necessarily has to partner with an insurer.

The committee has also recommended strict requirements of confidentiality to protect the data of policyholders, and has proposed defined entry and eligibility criteria, boundary conditions, process flow, timelines, success factors and exit parameters for the applicants, along with appropriate controls for protection and risk management.

"At the same time, the process and criteria would be flexible to provide a conducive environment for encouraging and enabling a wide variety of experimentation, including provisions for no-enforcement action orders, waivers and relaxed reporting requirements," it said.

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Source

India: International Financial Services Centres to have unified regulatory authority – Asia Insurance Review

The Indian cabinet has approved the establishment of a unified authority to regulate all financial services in International Financial Services Centres (IFSCs) in India. This would be effected by enacting a new law through the International Financial Services Centres Authority Bill, 2019.

The first IFSC in India to be set up is the Gujarat International Finance-Tec City (GIFT City). It is currently the only IFSC in the country.

At present, the banking, capital market and insurance sectors in the IFSC are regulated by their respective sectoral regulators, that is, the Reserve Bank of India (RBI), Securities & Exchange Board of India (SEBI) and Insurance Regulatory and Development Authority of India (IRDAI), respectively.

IFSCs require focussed and dedicated regulatory environment
The development of financial services and products in IFSCs would require focussed and dedicated regulatory interventions. Hence, a need was felt for a unified financial regulator for IFSCs in India to provide a world class regulatory environment for financial market participants.

In view of the regulatory requirements of IFSCs and the provisions of existing laws of the financial sector, the Ministry of Finance has piloted the draft Bill to set up a separate unified regulator for IFSCs.

Main features of the Bill
Management of the IFSC Authority:
The Authority shall consist of a chairperson. One member each will be nominated by the RBI, SEBI and IRDAI and the Pension Fund Regulatory and Development Authority (PFRDA). In addition, two members will be nominated by the central government. Two other whole-time or part-time members will also be appointed.

Functions of the Authority
The Authority shall regulate all such financial services, financial products and financial institutions (FIs) in an IFSC which have already been permitted by the financial sector regulators for IFSCs.

The Authority shall also regulate such other financial products, financial services or FIs as may be notified by the central government from time to time. It may also recommend to the central government such other financial products, financial services and financial institutions which may be permitted in the IFSCs.

Powers of the Authority
All powers exercisable by the respective financial sector regulators (RBI, SEBI, IRDAI, and PFRDA) under the respective Acts shall be solely exercised by the Authority in the IFSCs in so far as the regulation of financial products, financial services and FIs that are permitted in the IFSC are concerned.

Processes and procedures of the Authority
The processes and procedures to be followed by the Authority shall be governed in accordance with the provisions of the respective Acts of Parliament of India applicable to such financial products, services or institutions, as the case may be.

Grants by the central government
The central government may, after due appropriation made by parliament by law in this behalf, make to the Authority grants of such sums of money as the central government may think fit for being utilised for the purposes of the Authority.

Transactions in foreign currency
The transactions of financial services in the IFSCs shall be done in the foreign currency as specified by the Authority in consultation with the central government.

GIFT City has been ranked as third most promising financial services centre globally, in a half-yearly report in 2018 by The China Development Institute (CDI) in Shenzhen and Z/Yen Partners in London.

The ranking takes into consideration five major factors namely business environment, human capital, reputation, infrastructure and financial sector development. This ranking should build further confidence in investors to set up operations in GIFT IFSC.

TOP

Source

LIFE INSURANCE

First-year premiums of life insurers up 5.32 per cent in April-January - Financial Express – 11th February 2019

First-year premiums of life insurance companies stood at Rs 1.59 lakh crore between April and January, a rise of 5.32% compared to the previous fiscal.

While private insurance companies saw a growth of 22.92% in first-year premiums, Life Insurance Corporation of India (LIC) saw a negative growth of 1.83%.

The data from Insurance Regulatory and Development Authority of India (Irdai) showed that LIC saw its first-year premiums at Rs 1.05 lakh crore in April to January 2019, against Rs 1.07 lakh crore in the previous fiscal.

Market participants say that the single-digit growth for the industry is due to the weak performance of individual single premiums and group non-single premiums.

"In this financial year, performance of LIC has remained weak, especially in individual single premiums. However, segments of individual non-single premiums and group single premiums grew in single digit.

On the other hand, private players have seen good amount of growth in all segments barring group non-single premiums," said a senior official from a leading company. The market share of LIC stands at 66.26% at the end of January 2019.

Private insurers saw first-year premiums at Rs 53,645.06 crore in April-January against `43,643.15 crore in the previous fiscal. In the current fiscal so far, insurance companies such as Aditya Birla Sun Life, India First Life Insurance and Tata AIA Life saw premiums growth in excess of 60%.

While HDFC Life and SBI Life witnessing a premium growth of 38.45% and 27.32%, respectively, showed the data from Irdai.

For January, life insurers saw first-year premiums at Rs 17,419.76 crore against Rs 12,715.89 crore in the previous fiscal — an increase by around 37%. Officials say last two months will be strong as investors will invest in life insurance for tax saving.

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Source

Life Insurance: Private insurers' premium collections up 10 per cent - Financial Express – 11th February 2019

Individual annual premium equivalent (APE) growth for private sector life insurance companies was modest at 10% in January 2019 translating into year-to-date (YTD) growth of 11%. ICICI Prudential Life witnessed sharp rebound with 9% year-on-year (y-o-y) growth after reporting decline over the past three months.

On the other hand, SBI Life was flat as compared to about 17% growth over the past three months. Meanwhile, net mutual fund equity inflows continue to weaken. Against this backdrop, improving share of protection business augurs well for supporting value of new business (VNB) growth of key players and in that sense makes APE growth less relevant.

Individual APE reports growth

Private sector players reported modest 10% year-on-year (y-o-y) growth in individual annual premium equivalent (APE) in January 2019, lower than 14% y-o-y growth in December 2018. Growth rate had moderated in April-July 2018 but has picked up in later months prior to recording some sluggishness in November 2018 and inching up again.

HDFC Life reported 2% y-o-y growth in individual APE, better than 3% y-o-y decline in December 2018 and 20% y-o-y decline in November 2018. Its business has been a bit volatile this year with 4-37% growth during May-October 2018.

ICICI Prudential Life saw strong improvement in January 2019, recording 9% y-o-y increase in individual APE post sharp decline in the past few months. Management had guided an improvement in volumes in 4QFY19. The company has worked on monthly paying policies.

On considering overall (individual and group) adjusted APE including accrued but not received premium, its APE, according to a company release, was up 16% y-o-y.

SBI Life's individual APE growth was muted at 1% y-o-y in January 2019, especially against the backdrop of 24% growth in December 2018. Its growth has been volatile; the company reported 6-27% growth in preceding six months (YTD growth of 14%), much below 30%+ reported during FY2016-18. According to its management, its focus has been on streamlining its processes and increasing share of the protection business (up 140 bps q-o-q in 3QFY19 to 7.3%).

Max Life revived growth of individual APE to 35% post slowing down in the past two months. The company has increased focus on ULIPs—a likely reason for superior growth of the company. Additional investment in proprietary channels will further fuel growth.

Birla SL reported 81% growth in individual APE, continuing its high growth momentum (YTD growth of 70%) as it continued to make inroads in HDFC Bank. Tata AIA was up 46% translating into YTD growth of 63%.

Net MF equity inflows continue to decline

Mutual fund inflows to equities declined, with inflows at `55 billion (bn) in January 2019 as compared to `66 billion in December and `86-107 billion in the preceding six months. This is the lowest inflow since recent correction in equity markets.

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Source

Five important things for getting right life insurance cover: Read policy documents carefully - Financial Express – 11th February 2019

Life insurance is a critical part of your financial portfolio. Therefore, you must ensure your policy is as per your expectations. Mistakes, if any, need to be fixed immediately. Remember that you won't be around when the policy claim is made. And therefore, mistakes left unfixed could financially distress your family. Let's look at five steps to take after receiving your policy document.

Check if the policy is as expected

As soon as you receive the policy document, take the time to review it. Go through the contents of the document in detail. Ensure that the policy is as per your expectations, and nothing is amiss. Some key features to ascertain are the sum assured, policy tenure, the amount of premium you need to pay, and frequency of premiums. Also, ascertain the kind of policy you have received. For example, you wanted a term plan but were accidentally sold a ULIP. If you're in doubt about these matters, call and speak with the insurance company.

Personal & nominee details

If your policy details are correct, your nominees will have an easy time making a claim. Ensure that your policy document correctly lists information such as personal details, bank details, contact details and nominees. Any errors made here need to be corrected immediately. This should be easy to do. You can log on to the insurer's customer portal to initiate the edits. Alternatively, you could email or call them. This would prevent confusions during the claims process.

Tell your nominees

Your nominees—typically your spouse, children, or parents—need to be informed that you have purchased a life cover and that they are its beneficiaries. The policy should be accessible to them. You must also walk them through the details of the policy. Most policies have a sum assured. But many new life insurance products also have a host of add-ons whose exact benefits may confuse your family. For example, a term plan with an income rider pays out not just a sum assured but also a monthly income for 10 years. You must explain to your nominee what this rider means for them.

Pay premiums on time

Check the frequency at which premiums need to be paid. Most people prefer annual premiums while others like it monthly or quarterly. Ensure you know the due dates and have cash in hand to pay the premiums. It would be ideal to automate your payments through an ECS mandate. A missed premium would lead to a lapsed policy leaving your nominees without coverage—a situation you can wholly avoid.

Don't like the policy? Return it

If you find that the policy doesn't meet your requirement, use the free-look period. In it, you can return the policy in 15 days and get a refund. This is a standard procedure for all life insurance policies. If you have availed the policy through a distance marketing channel, you have 30 days to return it. However, make sure you have valid reasons for returning the policy. That said, you still need life insurance, so you must get the policy that best meets your requirements.

Lastly, don't settle for one level of coverage. As you age, your income will increase, and your family's lifestyle will also evolve. Ensure that the coverage you have today will be enough for your family's evolving needs. Therefore, every few years, revaluate your coverage and get additional coverage if required.

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Source

GENERAL INSURANCE

Par panel for insurance coverage to all properties in disaster-prone area – The Times of India – 13th February 2019

A Parliamentary panel Tuesday suggested a comprehensive insurance coverage to all properties located in a disaster prone area and claims be settled in a fast-track mode.

The country has become all the more vulnerable in recent years to floods, droughts, cyclones, earthquakes, landslides, avalanches etc. due to factors such as climate change, deforestation, encroachments etc. our country's geo-climatic conditions as well as its high degree of socio-economic vulnerability makes it one of the most disaster-prone countries in the world, the panel noted in its report.

Out of 36 States and Union Territories, 27 of them are disaster-prone, the Standing Committee on Finance said in its report presented in Parliament said.

The panel headed by senior Congress leader Veerappa Moily studied the recent devastating cyclone or floods or landslides in Odisha, Andhra Pradesh, Tamil Nadu, Karnataka and Kerala and the financial constraints faced by the affected states in meeting their relief, rehabilitation and reconstruction expenditure.

The Committee believes that any investment on mitigation and prevention of disaster risk will go a long way in building the capacity for significantly reducing expenditure on relief and disaster response.

"Towards this end, the Committee desire that comprehensive insurance coverage should be provided to all the properties (including public properties) located in the disaster prone area / zone and all insurance claims including crop insurance should be settled in a fast-track mode," it said.

In view of the diversity in geographical, social and economic factors across different regions in the country, the report said, a flexible and pragmatic approach should be adopted towards relief, rehabilitation and reconstruction.

"Further, provision should be made for immediate/automatic release of advance amount on adhoc basis from NDRF in cases of natural disasters of "rare severity" so as to enable the affected states to take up immediate relief work, pending the visit of the central team and completion of other procedures. Safeguards may however be provided to ensure that the funds made available are well utilised," it said.

TOP

Source

Pvt players fare better in claims - Deccan Chronicle – 12th February 2019

With better underwriting efficiencies and authority to make selection, private general insurance companies fare much better than their public counterparts when it comes to overall claims ratio.

In FY18, private general insurers had an average claims ratio of 75.46 per cent across different segments and this had improved from 79.10 per cent in the previous fiscal. Last fiscal, the average claims ratio of public general insurers stood at 93.73 per cent, which had improved from 100.02 per cent in the previous fiscal. Among the PSU insurers, National Insurance Company had the highest loss ratio of 114 per cent.

Specialized public insurers like Agriculture Insurance Company and Export Credit Guarantee Corporation of India had loss ratios of 102 per cent and 135 per cent respectively.

According to a top industry official, public insurers have very limited freedom to make selection compared to their private counterparts. They also have large number of offices and their size restricts them from bringing in underwriting efficiencies.

Further, they also have a larger exposure to third party motor and group health policies, whose contribution to the total loss ratio is higher. Health, as a segment, has a claims ratio of 92.21 per cent, but the standalone private health insurers are better off with a loss ratio of 59.58 per cent. Most of the private insurers have cut their exposure to loss-making group covers and have been focusing on retail health.

TOP

Source

Govt insurance firms post huge losses as merger delay hits business - Business Standard – 9th February 2019

With the merger exercise of three public sector general insurance companies —National Insurance, United India Insurance and Oriental Insurance — going slow, vacancies are piling up.

According to rough estimates, in the officers' grade alone, close to 600-900 posts are vacant since the last one year. At the clerical and subordinate level, the staff shortage is around 12,000, said sources in the companies.

The impact is already telling on the financial performance of the companies. In addition, at least two firms — National Insurance and United India Insurance — significantly lost market share.

While National lost market share from 10.78 per cent in December 2017 to 8.63 per cent in December 2018, United India Insurance came down from 11.02 per cent to 9.27 per cent over the same time span.

The three insurance companies have posted high losses in Q2FY19, given their premium growth reduced and provisions rose. Multiple reasons accounted for the losses, including manpower crunch and lack of clarity on merger.

"Lack of clarity on merger was a reason for the premium to come down. Shortage of manpower was another reason. Further, the firms had to make huge provisions over third party motor losses," said a senior official of the public sector general insurance sector.

KEY PERFORMANCE INDICATORS

	Market share up to Dec 2018 (in %)	Market share up to Dec 2017 (in %)	Growth in gross direct premium underwritten up to Dec 2018 (in %)	Profit/loss for Q2 FY19 (₹ cr) Profit after tax	Profit/loss for Q2 FY18 (₹ cr)	Combined ratio for Q2FY19 (in %)	Combined ratio for Q2FY18 (in %)	Staff strength as on 31.3.2016
National Insurance	8.63	10.78	(9.52)	(707)	90	165.28	121.92	15,079
United India Insurance	9.27	11.02	(4.48)	(868) (PBT)*	(36)	156.70	133.92	16,345
Oriental Insurance	7.75	7.72	13.61	(240)	200	149.79	133.03	13,923

SOURCES: Companies, BIFS; *Profit before tax

Last year the government made amendment in the Motor Vehicle Act, 1998, which stipulated almost ten-fold increase in the minimum compensation for injury or death due to road accidents. According to a senior official at a private sector general insurance firm, while higher provisioning norms apply both private and public sector firms, the private sector companies have been more prudent in selecting the category mix.

For example, they remained cautious in exposure to riskier insurances such as commercial vehicle insurance.

For United India Insurance, loss (before tax, as after-tax figures were not available) in Q2FY19 was Rs 868 crore (against a loss of Rs 36 crore before tax in the corresponding period last fiscal). For National Insurance, the loss was Rs 707 crore in Q2FY19 (against a profit of Rs 90 crore in Q2FY18).

Lastly, for Oriental India Insurance, the loss figure stood at Rs 240 crore in Q2FY19 (against a profit of Rs 200 crore over the corresponding period in FY18).

While the government has not put any official freeze on recruitment, there has been no fresh recruitment since February 2018 as the Union Finance Ministry advised the companies to put the new staffing plan on hold till the merger exercise was complete, according to a top official of a public sector general insurance company. Notably, in the next two to three years, about 25 per cent of work force, especially in the clerical level is expected to retire.

Each year, every public sector general insurance firm recruits 200-300 new staff at the officers' level, in general. The recruitment at clerical and subordinate grades are on hold for the last four to five years due to cost-cutting measures.

"We will take up the matter of staff crunch with the government," said a senior executive of National Insurance.

According to K Govindan, General Secretary of the General Insurance Employees' All India Association, each of the state-owned general insurance firms needs to recruit at least 3,000 clerical and subordinate staff. Therefore, at the clerical level, the total staff shortage stands at close to 12,000.

In 2007-08, when the total underwritten premium of the four public sector general insurance companies was around Rs 16,831 crore, staff strength in grade 3 (clerical) and grade 4 (subordinate) was around 43,654, according to data from General Insurance Employees All India Association.

According to Govindan, in 2017-18, while the total underwritten premium rose to Rs 67,920 crore, the staff strength in the two categories reduced to nearly 33,386.

In 2018, ahead of the government announcing its plans to merge the three public sector general insurance companies, National Insurance had planned to recruit about 600 people at the clerical level. However, the recruitment plan was put on hold on account of the merger plan, said people with knowledge of the matter.

As on March 31, 2016, the total staff strength of the four general insurance companies was about 64,130 — with United India Insurance at 16,345; Oriental Insurance at 13,923; National Insurance at 15,079; New India Assurance at 18,783 — according to data available with the Union finance ministry.

The fate of the merger of the three general insurance companies is also in fire, as it would depend upon the policy stance of the government elected in the upcoming general elections, said a senior official of public sector general insurance firm.

In the February 2018 Budget, the central government announced its plan to merge three public sector general insurance firms —United India Insurance, National Insurance and United India Insurance.

TOP

Source

HEALTH INSURANCE

As Ministry drags feet on policy, kids with rare diseases pay the price - The Hindu Business Line – 14th February 2019

The ongoing tussle between the Union Health Ministry and the All India Institute of Medical Sciences (AIIMS) over providing treatment to children with rare diseases is fast turning into a humanitarian crisis.

And caught in the crossfire are siblings Arshi (17) and Ubed (15), who first came to limelight as the first set of kids in New Delhi to get the costly Enzyme Replacement Therapy (ERT) for treating their rare genetic condition — Mucopolysaccharidosis I (MPS I).

"While both my children require the drugs every week, we have not received treatment for more than seven weeks in a year," Ayesha Begum, mother of the siblings, told *BusinessLine.*

Last year, after the Health Ministry did a U-turn and said that the National Policy for Rare Diseases 2017 is being put on hold and after the Rs100-crore corpus announced for treatment of rare diseases was withdrawn for lack of allocation, Ubed and Arshi's treatment also came to a halt at AIIMS. On February 8, the Delhi High Court called this move of the Ministry, a "somersault", and directed AIIMS to restart the treatment.

Health deteriorates

While the Health Ministry is still formulating its new policy, which, according to Union Health Secretary Preeti Sudan will take close to nine months, doctors from AIIMS said that in pursuance of the court's previous orders, they had purchased Enzyme Replacement Therapy vials, worth close to Rs67 lakh.

"The Health Ministry has neither paid for it nor has given any sanction for administering it," AIIMS submitted to the HC.In its counter, the Health Ministry stated that AIIMS had not informed the ministry about the purchase of vials, which is documented in the HC order.

Meanwhile, with lack of treatment, the health of the children has deteriorated. While Arshi has now been relegated to a wheel-chair and has stopped going to school, Ubed has started losing balance while walking, Ayesha said. Ayesha had moved the Delhi High Court last year against the Union of India and AIIMS to make drugs, which are prohibitively priced, available for children afflicted with rare diseases.

"Nearly 300 more kids, who are suffering due to lack of treatment, joined the public interest litigation. Out of these children, barely thirteen or so are receiving treatment under the Employees' State Insurance Corporation (ESIC) scheme," said Ashok Agarwal, the petitioners' advocate.

TOP

Source

Should you port your health insurance policy? - The Economic Times – 14th February 2019

Delhi-based Ritesh Singh didn't like the reimbursement limits for different medical procedures in his existing health insurance policy. The 36-year-old then decided to port his existing health insurance policy to another/new health insurer. With the existing health insurance company, he had a 4-year-old policy with a sum insured of Rs 2.5 lakh, which included a cumulative bonus of Rs 50,000.

"I called my insurance agent and he told me that I can easily make the switch to a new health insurer with the same sum insured (not less than that) without losing any benefits I have had accumulated with the previous insurer. He also told me that I can port a sum insured of at least Rs 2.5 lakh and if I want to increase the sum insured while switching the policy, I can do that too," said Singh.

Singh went to a new health insurer to get some more clarity on portability as there were many things he was unclear about. It was then he found out that the insurance agent had not told him that the insurance benefits carried forward from his existing policy would be capped up to Rs 2.5 lakh (the sum insured which he was getting with the existing health policy) when he ports his policy to the new health insurer. And, any sum insured above that will be treated as new/fresh sum- insured which would be treated as a new policy in terms of benefits provided by the new health insurance company.

Singh had been thinking that if he ported his policy to another health insurer with additional sum insured, the new insurer would provide some additional benefits.

Hence, before applying for portability Singh took detailed advice from the new health insurer. The new insurer informed him that if the insurance company to which he is porting to does not have a policy with the exact sum insured of Rs 2.5 lakh, then he will have to opt for the nearest higher sum insured available to them, say Rs 3 lakh. "So, in this case, you will get full continuity benefit for Rs 2.5 lakh to the extent of waiting periods served in the previous policy (say 4 years in Singh's case) but you will not get the benefit on the enhanced sum insured to, say, Rs 50,000. For this balance of Rs 50,000 we can also apply for a waiting period of 4 years for pre-existing disease, however, this can vary from plan to plan," explained the new health insurer.

Nevertheless, you can even go for a higher sum insured than what the new health insurer is providing but again, you will get no additional benefit on the increased sum insured. Also, there are certain terms and conditions which you need to fulfill to get higher sum insured, else the insurer can reject your application.

After getting to know about what health insurance portability means, Singh eventually applied to switch to the new health insurer.

Here's the process of porting policy

When you want to port your health insurance policy, you need to approach the new health insurer at least 45-60 days before the expiry of your existing health insurance policy. Once you are there, you need to fill a proposal form for portability, details of previous year policy copies and then apply for portability. On receipt of the request, the new health insurer will approach the existing insurer to know your medical and claims history. Understanding the situation, the new health insurer can accept or reject the proposals based on the information received and the underwriting guidelines.

Once the new health insurer obtains all the details, they have to take a decision on whether or not to accept porting of the policy within 15 days. If the insurer fails to do so, they will have to compulsorily accept the application.

Nikhil Apte, Chief Product Officer, Royal Sundaram General Insurance told EconomicTimes.com that the company post evaluation on the various medical underwriting parameters can reject, accept the case or accept the case with a fresh waiting period that can be applied on the additional sum insured if opted by the insurer. Also, when a policyholder opts for portability, medical underwriting happens on the current health status of the policyholder and not how the policyholder was when he purchased the policy for the first time. Basis the current health status, the policyholder may be subjected to co-pay (It is a fixed amount paid by an insured for covered services) or loading premium (increase in the premium amount).

"Let's say you bought a policy 4 years back, but you didn't have diabetes or thyroid at that point. But at the time of porting, it is found that you are suffering from diabetes or thyroid, then in that case, we can suitably apply loading or co-pay to the ported policy," said Apte.

You should also know that you may have to shell out more premiums after switching your policy to another health insurer as explained above. Therefore, you should figure out the reasons why you want to port your policy before doing so.

When you should think of portability

It might be confusing for you to decide when to go for health insurance portability and move to another policy. Therefore, to make this situation easy, you need to analyse the reason why you need to port.

Mahavir Chopra, Director - Health, Life & Strategic Initiatives - Coverfox.com says that one should be careful and opt for portability only when the differential benefits offered are compelling and solve an unsolved need with respect to your family's long-term healthcare requirements. "For instance, a health insurance plan that offers a better restore benefit or may be in cases when an insurer has a larger number of hospitals under its network or some plan that is customised to a chronic illness that one of your family members suffer," he said.

These reasons can help you understand more about when you should ideally go for portability. Vaidya Nathan Ramani, head, Product and Innovation, Policybazaar.com said that porting should be preferred when you are not satisfied with your current insurer's service/claim payment on a genuine case or coverage or features being offered in another product are of more personal value. "However, you should look at porting only if you have not had a difficult history of claims as any issue that is seen to persist in the future will diminish the chance to get portability," he added.

When you start getting poor services: It might happen that your health insurance company over a period of time may not provide you with better services and doesn't live up to the promised quality of service. "Younger consumers today should opt for portability or change in the insurance plan, only when they are offered an alternative insurance plan that is offering differential benefits. Slightly older consumers should look for a change when they are unhappy with the service/claims experience," said Chopra.

When an existing insurer is not giving you additional cover: If your existing health insurance provider is not able to provide you sufficient cover against any specific health issues which are of a concern to you then in such a situation you should look at porting your policy.

Apte said the existing insurer may not have a higher sum insured the customer is seeking or may not be comfortable giving a higher sum insured due its underwriting capability limitations. "Some companies focus only on sum insured up to Rs 10 lakh, while they may not have 50 lakh sum insured available or they may not be comfortable giving that higher sum insured in a particular channel and/or geography while the another insurance company may be open to it and can have better underwriting practice for risk selection," he said.

When you get better option from competitors: You may get a better deal in case of age caps for renewal, policy premium, limits on room rent, or co-payment clauses, etc. Due to stiff competition, there are chances where you can avail same services at a cheaper premium price.

When transparency in policy document becomes an issue: At times there may be some hidden clause which you may not be aware of while buying the policy. However, when it comes to making claims, these clauses may become a major concern during emergencies. Therefore, in that case, you can consider shifting to a provider who is transparent in their policy documents.

Things you should consider

The nature of the policy you wish to port remains same before and after porting, that is, if it was an indemnity plan then it will remain as such and cannot be converted into a defined benefit policy by porting to a new insurer. Obviously, you can port a policy (say indemnity plan) to another insurer only if

the latter provides policy options of similar nature, i.e., indemnity plans. "Defined benefit insurance plans cannot be ported," said Apte.

The new insurer will consider the porting request as a fresh application and a complete evaluation will take place. Thus, it is important for you to ensure that there is no lag or discrepancy in sharing medical history while submitting the portability form to avoid rejection. The new health insurer can deny the portability request if you have a pre-existing disease or have any health conditions such as diabetes, high blood pressure, heart related ailments which require frequent hospital visits.

Wrong or incorrect information and non-availability of previous policy documents can also lead to rejection of a portability application. Ashish Mehrotra, MD & CEO, Max Bupa Health Insurance said that the detail of the policyholder such as medical records, claims history is provided by the existing insurance company to the new health insurance company. "The insurer further extracts your details within seven working days through a common data sharing portal which is developed by IRDAI to ensure that the given information is correct," he said.

Make sure that you are aware of the different kinds of features provided by various insurers. "While porting the existing policy, it is possible for you to transfer the credit gained for pre-existing conditions and time-bound exclusions. Hence, analyse the policy documents of various health insurers carefully before applying for portability," said Mehrotra.

TOP

Source

Adding a top-up health plan can benefit you – Mint – 13th February 2019

Health insurance is important because, perhaps, it is the only efficient tool to battle the rising cost of medical care. There are more than 25 non-life companies that offer health insurance products.

Your first policy is an indemnity product that pays for hospitalisation expenses, but before buying it, you should consider some options to make sure you are able to keep your costs down while ensuring proper cover. We tell you how you can make use of a floater policy and top-up plans to your advantage.

For an individual

Going by the basic health cover launched by the government for the underprivileged, a minimum sum insured or insurance cover of Rs5 lakh is essential. But if you live in a bigger city, you will need to bump up your cover and a top-up plan can do that effectively. A top-up is an indemnity policy that pays for hospitalisation, but only after a certain threshold or a deductible limit. A deductible is the portion your top-up plan will not pay for. So if you have a basic health plan that covers the deductible amount, any payments over that can be covered through a top-up plan. This is a cost-efficient way to increase your health cover.

The deductible feature of a top-up plan makes it cheaper as it reduces the liability of the insurer. The higher the deductible, the cheaper is the cover. But make sure you opt for an aggregate top-up plan that calculates the deductible amount from multiple cases of claims.

For a family

If you have a family and are in the market to buy health insurance, you could consider buying a floater policy, which covers the entire family under a single policy and, therefore, is a much cheaper alternative compared to buying individual plans for each member. But keep in mind that a floater considers the entire family as one unit; so if one member makes a claim, the overall cover reduces by that much for the entire family in a policy year. So to benefit from a floater plan, you need to ensure a few things. First,

make sure you take adequate cover, as one incidence of hospitalisation can expose the entire family. Second, floaters work best when the family is young or the age gap between the spouses is not much. If a member is very old or not in good health, including this person in the floater may not make sense.

You can also take a top-up floater plan that covers the entire family after a basic deductible is crossed, but do take the aggregate plan.

TOP

Source

Why timely renewal of health cover is critical - The Hindu Business Line – 11th February 2019

Joe has a health insurance policy which was due for renewal on December 1. By the end of February, he had to undergo a small surgery and decided to renew his health policy on February 1. But he was unable to do so and lost all his policy coverage. This created undue financial stress for him, as he had to bear the medical expenses, entirely. To avoid this and keep the policy going, it is better to pay up before the due date. Here's what you should know about renewal of health policy.

Grace period

Grace period is a saviour in disguise when due date is missed. It is a time-frame given to policyholders to pay the premium due without any penalty. For health insurance policies, the grace period given is usually 30 days. Once the premium is paid, the policy coverage will continue without loss of benefits such as waiting periods and coverage of pre-existing diseases.

According to Vaidya Nathan Ramani, Head Production and Innovation Policybazaar.com "Normally, health policy renewal reminder is triggered 45 days prior to the due date. The insurer has to accommodate the same terms and conditions of the policy until the due date. But you will not be covered under the policy in the grace period given to pay the premium..." Post the premium payment, all benefits of the policy would be restored and claims paid.

Note that, you cannot revive or renew your health policy, post the grace period. So when you pay the premium after that period, it will be tantamount to you taking the health policy for the first time. This means, you will have to go through procedures such as waiting period, medical check-up once again.

The problem with purchasing new policies is that, if you happen to develop any health issues or complications, you might not even get a policy, adds Vaidya Nathan Ramani.

Benefits lost

If you don't renew your health policy on time, there are some benefits you may lose. The first and foremost being the continuity benefit — typically, the waiting period benefits. It is a period of time that has to pass before some or all of your health coverage can begin. Suppose your policy has a four-year waiting period and you had already waited for two years, now, when you don't renew the health policy, you will lose this key advantage and have to begin all over again.

"Another subset of continuity benefit is the specific illness waiting period, which is generally one to two years. You will lose on this benefit as well, if you don't renew your policy", says Sapna Desai, Head marketing and communications, Cigna TTK Health Insurance.

Further, you will also have to forfeit the no claim bonus (NCB) if the health premium payment is not paid on time. The insurer gives a certain percentage as sum insured that comes as a bonus, known as NCB. This bonus gets accumulated over a long period up to a certain limit, provided you don't make any claim in between. For instance, if you have a Rs. 10-lakh policy and you have not made a claim and renewed it

on time, the insurer will give you an additional sum insured (say 10 per cent of the SI) as bonus. In this case, you will have Rs. 10 lakh policy plus Rs. 1 lakh as bonus. You will not be able to avail yourself of this benefit if you fail to meet the premium payment deadline.

Other benefits such as one-time discounts on premium may also be declined if the policy renewal is missed. Remember, by not renewing your health policy, you will also be letting go the tax benefits under Section 80 D.

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Source

Should you have a cancer cover? – Mint – 9th February 2019

Ways of insuring yourself

There are three ways in which you can cover yourself from cancer in the country, your regular health insurance plan, disease specific cancer insurance plans and critical illness policy, which cover cancer along with other critical illnesses. According to policies available on Policybazaar.com, an online insurance aggregator, on an average, for a 30-year old living in Mumbai and a sum insured of Rs10 lakh, the average annual premium for health insurance plans is Rs 9,762. It says the premium for disease-specific cancer plans is Rs 2,136 while the premium for critical illness covers for cancer is Rs 2,880.

Pros and cons

"A critical illness plan will cover you for multiple illnesses at once. It will become inconvenient for you to take a separate disease-specific plan for illnesses," said Suresh Sadagopan, founder of Ladder7 Financial Advisories. "When you start earning, you should first buy a health insurance policy, a super top-up policy after a couple of years and then at the age of 35 you can take a critical illness cover," said Sadagopan. "However, a critical illness cover has pre-conditions of medical tests and is more expensive than cancer-specific plans," said Kapil Mehta, co-founder of SecureNow.in, a web insurance aggregator.

What should you opt for?

In 2018, around 7.84 lakh people in India died of cancer, of which around 4.13 lakh were men and 3.71 were women, according to National Institute of Cancer Prevention and Research, a premier institute under Indian Council of Medical Research (ICMR). Heart diseases are also taking a heavy toll. Overall, cardiovascular diseases contributed to 28.1% of the total deaths and 14.1% of the total disability-adjusted life-years (DALY) in India in 2016, compared with 15.2% and 6.9%, respectively, in 1990, according to a study by Thelancet.com, an online medical journal. Hence, a critical illness policy is better than a disease-specific policy.

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Source

More money for Ayushman Bharat: Govt may increase funding for Modi's scheme next year, says Piyush Goyal – Financial Express – 8th February 2019

Finance Minister Piyush Goyal Friday said the government may provide more funds for the world's biggest health care scheme — Ayushman Bharat — next year.

In the last four months of its launch, the scheme has already benefited over 10 lakh people, he said while speaking at the sixth Global Fund Replenishment organised by Ministry of Health here.

"The government has already provided half a billion dollar funding for the programme. We expect to provide much more funds in the next year," he said.

The interim Budget presented last week has raised the allocation for Ayushman Bharat scheme to Rs 6,400 crore for 2019-2020.

"Unless we create a distress free health care system for 1.3 billion people in India, unless we look at health in a very holistic fashion right from preventive health care…we will not be able to take people out of distress that health care can cause particularly to lesser privileged," he said.

Improvement of infrastructure of health care also opens up huge opportunities for companies around the world to participate in effort to expand the health care system, he said.

The scheme aims to provide free health care to 50 crore people encompassing different dimension of family health care needs.

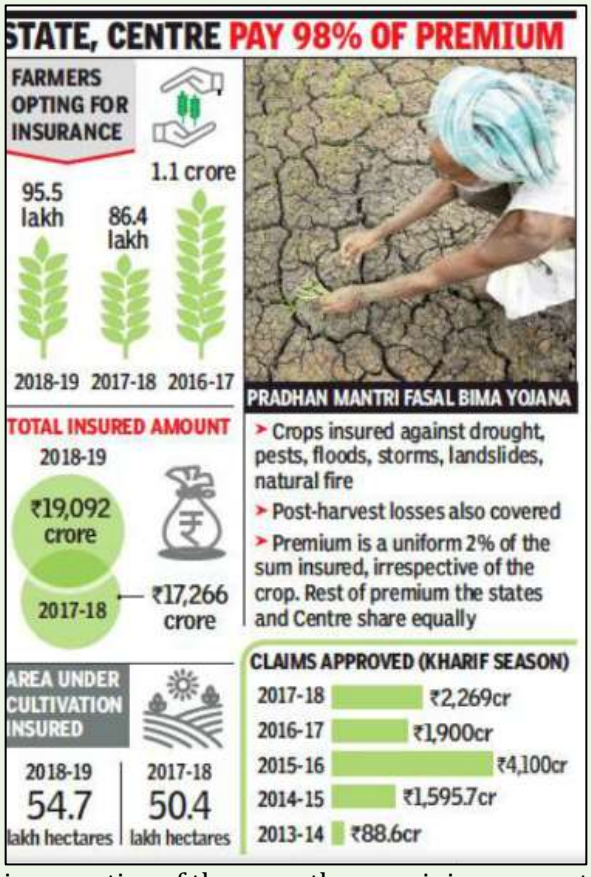
Referring to energy access to every household, the Finance Minister said, electricity will reach to every home by April of this year, a decade ahead of sustainable development goal.

TOP

Source

CROP INSURANCE

Drought sees 10 lakh more farmers take crop cover in Maharashtra – The Times of India – 15th February 2019



The number of farmers opting to insure their crops in the state has gone up by 10 lakh in the kharif season for 2018-19. In all, 95.5 lakh farmers enrolled under the Pradhan MantriFasalBimaYojana (PMFBY) against 86.4 lakh last year, says data compiled by the Maharashtra government.

The crop area under insurance too has gone up by 4 lakh hectares, taking the total insurance amount to Rs 19,092 crore.

Officials cited drought as one of the reasons for the jump. Field level officials said participation went up after July as there was a long dry spell and drought-like conditions started setting in. "Even previously, participation peaked during the drought years and reduced in a good rainfall year. This time too, farmers were waiting and watching and when they realised that it's going to be a rainfall-deficit year, they took to crop insurance," said a senior official.

Maharashtra has declared drought in 151 talukas and also in 4,500 villages. It got Rs 4,714 crore as aid from the Centre, and has decided to spend Rs 2,900 crore from its own funds towards drought mitigation.

In PMFBY, farmers pay just 2% of the premium, irrespective of the crop; the remaining amount is paid by the state and Centre equally. The farmers' share of the premium for the kharif season in 2018-19 works out to Rs 488 crore.

During drought, farmers are compensated for crop loss through the Centre's National Disaster Relief Fund (NDRF) and through claims under PMFBY. The state may announce a compensation scheme of its own, but in that case, farmers who have not opted for insurance are not given 50% of the compensation amount, said senior officials.

Experts and activists said generally farmers stay away from crop insurance due to the small percentage of claims approved. "Even if the premium amount looks small, it is still some investment that a farmer has to make and if his claims are not approved one year, he generally avoids future participation. But in a drought year, he wants to seek as much aide as possible," said Kishore Patil, a Swabhimaani Sanghatana activist from Aurangabad.

TOP

Source

MOTOR INSURANCE

Car and bike owners: check out changes in motor insurance rules - The Telegraph – 11th February 2019

Motor insurance in India is undergoing a transformation with the recent regulations introduced by the IRDAI that will address a major concern of the country — lack of insurance and under insurance.

In India, we see around 70 per cent of two-wheelers, 25 per cent of cars and around 40 per cent of commercial vehicles that ply on the roads are uninsured despite the law making third party insurance mandatory.

According to the road accidents report of 2017, more than 4 lakh road accidents took place, of which 1.34 lakh were fatal. The number of people who died in these mishaps stood at around 1.5 lakh — about 400 fatalities a day. These alarming statistics highlight the need to create awareness about motor insurance as a security tool to compensate for the damage caused.

I have always seen people excited about their new two-wheeler or four-wheeler and looking forward to enjoying the first ride. However, I have not seen any such excitement to buy insurance to protect the same vehicle from possible damage.

Insurance is the last thing that people think of and is seldom there on their priority list. It is seen as an additional cost rather than something that will compensate for damage which is much more than the premium paid. The recent regulations for long-term third party motor insurance and higher sum insured for compulsory personal accident cover might change the attitude of people to some extent.

Long term third party cover

The IRDAI recently made long-term third party motor insurance policy mandatory for new four-wheelers and two-wheelers for a period of three and five years, respectively. The regulation will address the apathy for motor insurance in the country.

While some may feel that buying a long-term cover for a car or a two-wheeler will be heavier on the pocket as premium will be for a longer tenure, one should consider the benefits associated with the same. It will remove the hassles of annual renewals of the policy, which will ensure that more vehicles on the road are insured for a longer period of time.

This is critical as most people are not aware that liability towards a third party death that a driver/rider may cause is unlimited, and an uninsured individual may end up being liable to pay crores of rupees.

This can be taken a step ahead where the regional transport office's (RTO) data and the insurance company's data are matched at the insurance information bureau (IIB). Using a good data match, we can figure out how many vehicles are uninsured irrespective of the number of years they have been registered. The RTO could send a notice to vehicle owners based on the record of uninsured vehicles.

If the police have an application on their handheld device / smartphone, they will also be able to identify the uninsured vehicles. This will help solve the issue of lack of uninsured vehicles.

Personal accident cover

I strongly believe that one must have an appropriate personal accident policy as it covers you against death or disability because of an accident and costs less than a cup of tea a day. It provides financial support to the policyholder if she/he is disabled after an accident.

The IRDAI's recent move to increase the sum insured for compulsory personal accident for the owner driver under the motor insurance policy to Rs 15 lakh is welcome as it ensures adequate cover for those taking the hazard of driving on Indian roads. It will help address the issue of under-insurance, particularly among two-wheelers, and provide a much-needed relief and financial support to the policyholder and their family members if she/he is disabled or succumbs to an injury while driving his vehicle.

Most people only buy a motor insurance policy at the time of purchase of the vehicle as it is a must for vehicle registration and delivery. After the formalities are met, many forget about it and don't bother to renew it as they consider it a hassle or an unnecessary expense.

Realisation only dawns when they are either caught by the traffic police and asked to produce insurance proof of the vehicle or if they unfortunately meet with an accident and hurt someone, the liability for which is unlimited.

Accidents can happen even to the best of riders and, therefore, I feel these steps by the regulator will ensure that in case of an unfortunate accident, more vehicles on the road are insured and you and your family are given a protective shield with a strong motor insurance policy.

TOP

Source

SURVEY & REPORTS

Health study flags insurance holes – The Telegraph – 11th February 2019

A three-state study has found that India's government-funded or private health insurance schemes that pay for hospitalisation have not adequately protected households from catastrophic health expenditures and rekindled the debate on how to achieve universal health care.

The study that examined sample households in Gujarat, Haryana and Uttar Pradesh found 28 per cent of insured households and 26 per cent of uninsured households faced catastrophic health expenditure that significantly altered their expenses on essential services.

"Health insurance in its present form does not seem to provide requisite improvement in access to (health) care or financial risk protection," health economists who analysed health-care spending by 12,134 households in the three states said in their report.

Their findings, published this week in the journal PLOS One, echo long-standing concerns among sections of health experts that insurance schemes that only cover hospitalisation costs continue to expose households to significant financial risk.

The Narendra Modi government had last year launched the Ayushman Bharat Pradhan Mantri Jan ArogyaYojana (PM-JAY) for 10 crore poor households — or 40 per cent of the population — that pays up to Rs 5 lakh per year per household for hospitalisation. The Centre and states pay the scheme's premium on a 60:40 ratio.

The three-state study probed health-care spending by households covered by earlier government-funded schemes — such as the Centre's Rashtriya Swasthya Bima Yojana (RSBY) that paid up to Rs 30,000 per year — and private health insurance. The households covered by the Centre's Rashtriya Swasthya Bima Yojana had the highest proportional prevalence (39 per cent) of catastrophic health expenditure followed by households with private insurance (23 per cent) and state insurance schemes (21 per cent).

The study found that average out-of-pocket or personal expenditure for in-patient care among the insured was about Rs 32,000 and about Rs 24,000 for the uninsured. The average out-of-pocket expenditure was highest (Rs 73,000) for people enrolled under private health insurance schemes and lowest (Rs 15,000) for people under the RSBY.

The researchers who conducted the study said their findings — reflecting similar results from earlier studies — highlighted the need to bolster public investments in primary care. "Sprucing up a dysfunctional primary care system should be the top priority," said Indrani Gupta, professor and head of the health policy research unit at the Institute for Economic Growth, New Delhi, and a member of the study team.

Health experts have long pointed out that outpatient consultations and diagnosis which are not covered by insurance — whether government or private — account for a large fraction of a household's out-of-pocket health expenditure. "Two-thirds of out-of-pocket spending goes into outpatient consultations — insurance for hospitalisation will have limited impact on most households' health spending," said Selvaraj Sakthivel, director of health economics, financing and policy at the Public Health Foundation of India, New Delhi, who was not associated with the study.

The government has pledged to improve primary care through 150,000 health and wellness centres providing free consultations, medicines and diagnosis.

But health experts have decried what they say is a far greater emphasis on PM-JAY and inadequate investments for the health and wellness centres. The interim budget for 2019-20 raised the PM-JAY budget by Rs 4,000 crore, or by 167 per cent, while the health and wellness centres initiative will get only Rs 1,600 crore — far less than what is required to make them truly functional.

"Between PM-JAY and health and wellness centres, the priority should have been on the health and wellness centres," Gupta said.

TOP

Source

INSURANCE CASES

Insurance firm fined for denying claim to Zirakpur resident – The Tribune – 12th February 2019

The Mohali District Consumer Forum has penalised a private insurance company for not giving claim to its client with regard to his treatment on a foreign land during his short visit there. The forum directed the ICICI Lombard General Insurance Company to settle claim of the complainant Jagdish Chander from Zirakpur, along with Rs 10,000 compensation, for his mental agony and harassment and Rs 5,000 as litigation expenses.

In his complaint, Jagdish said he had purchased the policy online from ICICI Lombard General Insurance Company, the opposite party's (OP) office, for undertaking journey to Australia for which he had paid a premium of Rs 7,230. The validity of the said policy for 85 days was from December 24, 2015, to March 17, 2016.

The complainant claimed that he had boarded flight for Australia on December 24, 2015, and had suffered an acute heart attack on March 13, 2016, following which he remained admitted in Sunshine Hospital in Australia for six days. "As validity of the policy was to expire on March 17, 2016, and revalidation of the same was done, an amount of 15,916 Australian dollars was spent on the above said treatment," said the complainant, who after returning to India requested the OPs for release of medical treatment amount. The insurance cover was said to be 50,000 US dollars.

According to the complainant, an executive from the OP office came to his residence in April 2016 and asked him to give an undertaking of being a patient of hypertension for easy release of the insured amount to which the complainant had objected. Thereafter, the complainant received a repudiation letter (dated April 28, 2016,) in which he found rejection of his insurance claim on account of pre-existing medical condition/ailment. However, the complainant claimed to have never been a patient of hypertension.

Giving it decision in favour of the complainant, the forum directed the OP office to settle the claim, along with compensation amount and litigation cost, within 40 days.

Deficiency in services

According to the complainant, an executive from the ICICI Lombard General Insurance Company office came to his residence in April 2016 and asked him to give an undertaking of being a patient of hypertension for easy release of the insured amount to which the complainant had objected.

Thereafter, the complainant received a repudiation letter (dated April 28, 2016,) in which he found rejection of his insurance claim on account of pre-existing medical condition/ailment. However, the complainant claimed to have never been a patient of hypertension.

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Source

Couple wins Rs 6L over medical insurance claim – The Times of India – 10th February 2019

A consumer forum observed that an insurance company not raising an objection to an insurer's intimation about an impending treatment and issuing an inward number, equals to its implied consent. The forum made the observations while ruling in favour of a couple, Nepean Sea Road residents, Salim and Dilshad Maladwala, after their reimbursement claim towards Sequential Programmed Magnetic Field (SPMF), a non-evasive osteoarthritis treatment, was rejected by the insurance company, as it was not covered under the policy. The forum said that on receiving the intimation, the insurance company should have informed them about the exclusion clause.

It stated that the company's initial permission and later refusal amounted to inconsistent behaviour. United India Insurance Co Ltd will now have to pay the Maladwala treatment cost of Rs 4.8 lakh, along with a compensation of around Rs 1 lakh.

The consumer forum pronounced two orders and did not accept the insurance company's reasoning that naturopathy treatment, acupressure, acupuncture, magnetic therapies, experimental and unproven treatment therapies, including drug experimental therapy which are not based on established medical practices in India, are not payable.

"The insurance company failed to prove that how treatment taken by the complainant was unproven. It is pertinent to note that after taking the treatment the complainant healed from her pain of knees," the forum said in Dilshad's case.

The two complaints were submitted before South Mumbai District Consumer Disputes Redressal Forum in June 2016. Both told the forum that they had pain in knee joints and that they had taken medicines from their family doctor, but only got temporary relief. Soon, they learnt about SPMF being offered by a Bangalore company, which had a centre in the city.

The couple told the insurance company that on December 28, 2013, they were told treatment would commence the following day. They stated that it would last for 21 consecutive days. The treatment went on until January 18, 2014, with no breaks on Sunday and holidays. They filed their claims. In June 2014, the insurance company repudiated it.

The Maladwala told the forum that the refusal was baseless, illegal and extremely discriminatory. "As SPMF treatment is proven technology and standard treatment accepted worldwide. It has proven to be effective and provides huge relief to patients, eliminating the need for knee replacement surgery, and it does not necessitate hospitalization," they claimed.

The forum ruled in favour of the complainants. "The opposite parties (insurance company and Health India TPA Services Pvt Ltd) have committed negligence in repudiation of the complainants' claim in addition kept deficiency in service and unfair trade practice towards the complainant," the forum said.

TOP

Source

Woman gets Rs 1.9L mediclaim on 'alternative therapy' – The Times of India – 9th February 2019

Observing that consumers should not suffer due to rigid, unreasonable and absurd clauses in insurance policies, a district forum has ruled in favour of a woman after her reimbursement claim towards sequential programmed magnetic field (SPMF), a nonevasive osteoarthritis treatment, was rejected by the insurance company on the grounds that it was not done under hospitalization.

"Considering the benefits of advanced technologies, various insurance companies are required to think of the interests of its consumers while drafting the terms and conditions of insurance policies instead of focusing on rejecting genuine claims on rigid and flimsy grounds," the forum said.

The forum directed ICICI Lombard General Insurance to pay the complainant, Sushila Arya, Rs 1.31 lakh towards reimbursement and around Rs 62,000 as compensation.

At present, there are some insurance companies that cover alternative therapies, but these are usually restricted to Ayush (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy)—an umbrella of non-allopathy treatments recognized by the Indian government.

The forum said that insured persons should not be made to suffer especially when advance technology and specialized infrastructural facilities made available at various hospitals help improve the patient's quality of life, saves time and eliminates unnecessary hospitalization. "The insurance company has wrongly repudiated the genuine claim of the complainant on absurd and rigid and unreasonable ground due to which she must have gone through mental agony," the forum said.

The insurance company told the forum that Arya's claim was rejected as her treatment didn't require hospitalization. But the forum pointed out that exclusion policy regarding time limit was not applicable on treatments like dialysis, chemotherapy, radio therapy and eye surgery, in which patients were discharged the same day.

The forum said the complainant submitted that the treatment was painless, cheaper and scientifically proven. It said that the insurance company had not produced information contrary to the submissions made by the complainant about the benefits of the treatment.

TOP

Source

OPINION

How to choose a life insurance policy to meet your needs - Financial Express – 14th February 2019

Each and every wealth management plan demands regular evaluation of the financial goals and objectives. In order to achieve them, it is very important to implement and practice a well-designed approach.

Talking about life insurance, though it is often overlooked as a financial planning tool, it can even serve a broad spectrum of needs for individuals with dependents. With a multitude of life insurance policies available, both offline and online, it is critical to choose the right life insurance policy with adequate sum assured.

It is important for each one of us to first understand that life insurance is a bond of trust and before researching or purchasing a term plan, it is imperative to evaluate what you actually want to accomplish with the policy.

Though the basic purpose of a life insurance cover is to ensure that the dependents do not have to grapple with a financial crisis in the absence of the policyholder, it is equally important to understand what your short and long-term goals are. When planning to buy a life cover, you must estimate the size of your financial liabilities including education and marriage of kids, home loan, retirement savings, etc.

Once you have rightly identified your needs and constraints, it will become easier for you to select the best policy for your individual circumstances and needs. Not to forget, life insurance is an essential financial product to buy and you would never want to goof up while making a decision. Here are some things to consider while buying a life cover.

Be Sure Between Term and Whole Life

The first and foremost thing to consider is whether you need life cover for a specific length of time (term) or indefinite coverage (whole life). Term insurance is typically one of the cheapest short-term insurance options that pay the total sum assured to the dependents in case of death of the policyholder. If death of the policyholder happens after the term of the insurance cover, the coverage expires or becomes cost prohibitive. Some of the insurance policies come with a conversion feature wherein the policyholder can convert the policy from term to whole life by getting some recertification done.

On the other hand, whole life insurance usually demands higher monthly premiums than term insurance and it pays a death benefit to the dependents regardless of when the policyholder dies. Additionally, whole term insurance even offers several other benefits, including flexibility in payment of premium and tax-deferred investing.

Don't Treat Term Insurance as Investment Product
Life insurance plans are not like traditional investment plans such as endowment or market-linked like the Unit Linked Insurance Plans. Though both the plans have an element of insurance, ULIPs are equity market-linked products with the potential to deliver returns as per equity market conditions. Life insurance is not a pure investment product because of the many charges associated with it. People purely looking for returns must not confuse life insurance with any kind of investment products.

Accept the 'Loading' By Insurer
Under many insurance policies, after making the policy seekers undergo medical tests, the insurers revise the premium. However, customers often do not accept the revised premium and rather go for another insurer. The revision in premium is usually done through the 'loading' process, i.e., asking extra premium on medical grounds. As a policy seeker in case you accept the loading, you can at least be sure that the insurer has accepted the medical grounds and the claims process will not be impacted because of it.

Don't buy in the name of minor
Many people buy policies in the name of minor children as the mortality charges would be low and hence the premium. But as children don't have any earning capacity, it doesn't make sense to buy insurance in their name. Instead, it should be bought in the name of the earning member of the family.

(By Santosh Agarwal, Associate Director and Cluster Head-Life Insurance, Policybazaar.com)

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Source

End-to-end digitization of the process means lower costs, time-to-market - Financial Express – 14th February 2019

Digital tech is disrupting business models across industries. In insurance, it is challenging traditional insurers to re-imagine their business models. Today, most customers' experience with their insurer is defined by a complicated buying process, an ambiguous underwriting procedure and, then, an uncertain claims process. For customers whose experiences are increasingly getting shaped by their interactions on Uber, Paytm, and Amazon and other such platforms, this experience is sub-standard. Insurers with pure-play digital models in other countries (e.g. China) have created end-to-end journeys that give a frictionless experience to the customer and are thereby challenging traditional insurers.

The opportunity at stake for insurers in India by digitally transforming their business models is significant. Digital driven re-imagination of customer journeys across the value chain of issuance, renewals, servicing and claims, can dramatically cut turnaround times by 60-80%, reduce customer complaints by half, optimise costs by 30-40% and build a business model ready for the future. For example, the issuance process for a health insurance policy can be made near-instantaneous through the thousands of agents selling these policies. This includes:

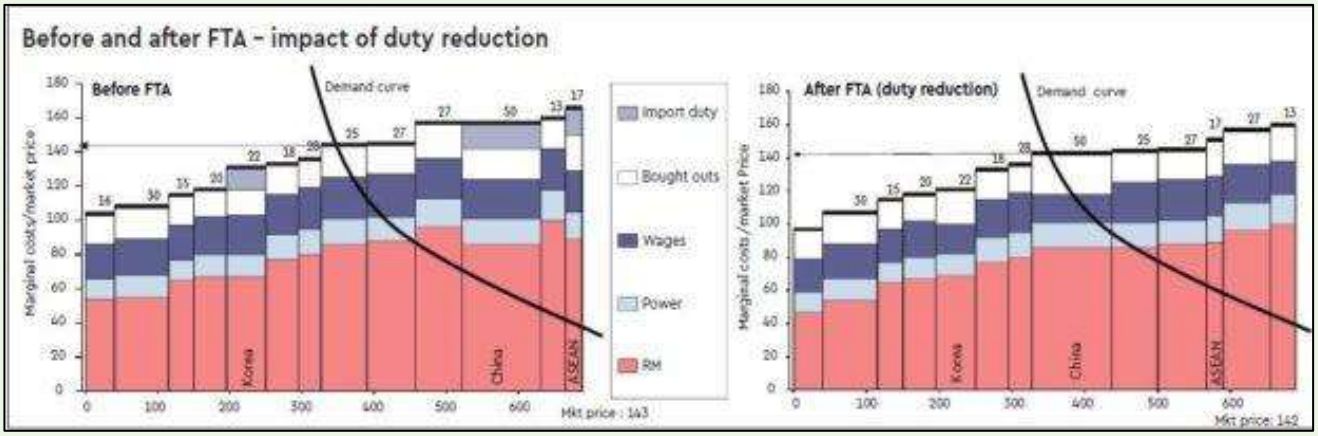
Intuitive digital front-end for agents, data validations built in to avoid re-work and few simple fields for fast form-filling. Overall, with less than three fields, a quotation can be provided in less than a minute, and with less than 10 fields, a policy can be issued in under five minutes. In addition, e-sign/ OTP-based customer consent (in future, possibly enabled through Aadhaar) can completely make the process seamless. BCG's study with insurance agents shows that more than 70% are willing to adopt such digital tools.

Automated underwriting with data-driven rule engines, automated checks and decisions, "swim-lanes" based workflows on policy issuance. Over time, this can be further enhanced with use of non-traditional data sources to increase accuracy of risk assessment leading to higher quality portfolio. Alternate data

sources include, for example, wearables and IoT data, data from other platforms such as healthcare platforms, and data on social footprint.

End-to-end digitisation of processes with minimal-to-no manual touch—even in scenarios where health tests are required—can significantly reduce turnaround times. For instance, OCR-based reading of test reports and AI interpretation of the results can reduce the time consumed.

Other innovation such as facial analytics can minimise the need for physical health examinations. While the efficacy of these technologies is still to be tested at scale, an innovation pipeline that factors in potential developments is critical for sustained transformation.



While several Indian insurers have initiated digital transformation programs, the impact is less than required. So, what does it take to successfully drive digital transformation?

Re-imagine customer journeys, not re-engineer: Take the customer perspective as the starting point, define the art of the possible (including learning from outside the industry), ensure end-to-end digitization.

Create agility @scale through cross-functional teams working with a minimum viable proposition based approach.

In our experience, an agile approach shortens time to market by half, reduces development costs and drives higher employee engagement.

Leverage partnerships: Companies need to recognise that they cannot build everything in-house and need to leverage partnerships for data and technology to scale up faster. Insurers need to continuously move towards a flexible, micro-services based IT architecture.

The right culture and value proposition to attract the right IT talent is critical. Change the terms of measurement: Build a dis-aggregated (e.g. step-wise turnaround times) but end-to-end view, move beyond averages to 90th and 99th percentile.

Sustained commitment to the transformation program from senior leaders. This cannot be delegated. Digitisation is already starting to transform the insurance industry.

The challenge—or opportunity—for insurers lies in determining the concrete steps to drive this revolution. Insurers successfully undertaking digital transformation programmes will capture a large share of value in the future.

(Pranay Mehrotra is Leader (insurance practice), BCG India and Pallavi Malani is principal, BCG Views are personal.)

TOP

Source

EPFO likely to retain this PF interest rate for FY 2018-19; Find out – Financial Express – 11th February 2019

New Delhi: Retirement fund body EPFO is likely to retain the interest rate on employees' provident fund at 8.55 per cent rate for the 2018-19 fiscal for its more than six crore subscribers, a highly-placed source said.

"The proposal for providing interest rate for the current fiscal would come up in the meeting of the trustees of Employees' Provident Fund Organisation on February 21," the source said.

"The interest rate would be retained at 8.55 per cent for the current fiscal as provided in 2017-18 in view of forthcoming Lok Sabha elections. The EPFO's income projections for the current fiscal would be tabled in the meeting."

However, the source did not dismiss the speculation completely that interest rate on EPF deposits for this fiscal can be more than 8.55 per cent in view of Lok Sabha elections.

The Central Board of Trustees headed by Labour Minister is the apex decision making body of the EPFO which finalises rate of interest on PF deposits for a financial year. Once approved by the CBT, the proposal is required concurrence of the Finance Ministry. The interest rate is credited into the subscribers account after the Finance Ministry's approval.

The EPFO had provided a five-year low rate of interest of 8.55 per cent to its subscribers for 2017-18. The body had kept the interest rate at 8.65 per cent in 2016-17 and 8.8 per cent in 2015-16. It provided 8.75 per cent interest for 2013-14 as well as 2014-15. The rate of interest was 8.5 per cent in 2012-13.

Other important issues that can come up for discussion in the CBT meeting next week include appointment of new fund managers and review of investment made by the EPFO in exchange trade funds (ETFs). The EPFO had started investing in the ETFs in August 2016. Presently it invests 15 per cent of its Rs 1.5 crore investible deposits at hand every year in the ETFs. It has invested around Rs 50,000 crore in the ETFs so far.

TOP

Source

Woof! Insurance for pets is here now – Mint – 10th February 2019

The pet population in India has grown to 10 million in 2014 and India is considered to be the fastest growing global pet market ($800-million-plus industry). Pets are family members you choose, and so you want to love them, take care of them – which like everything else comes at a cost. Let's try to understand what it means to take care of your pets and how you can cover them in the best possible ways with insurance.

Cost of healthcare

Having spoken to pet parents, I have understood that the cost of owning a pet depending on the age and the breed can be high. Healthcare is an important component when you have a pet. For instance, the annual routine healthcare expenses such as vaccination, deworming, tick treatment and minor illnesses in the first year when you get a dog are estimated to be in the range of Rs6,000 - Rs10,000, and then an average of Rs5,000- Rs7,000 every year.

Treatment for minor to a major illness such as cancer or heart disease can cost anywhere from a few thousands to lakhs. On a rough back-of-the envelope estimate, taking the average age of a dog at 12 years, the average lifetime healthcare expenses should be in the range of Rs2.50 lakh to Rs4 lakh.

The cover

Pet insurance policies in India, mostly are more "animal/bird" policies provided by public sector insurers. These cover animals like dogs, cats, horse, rabbits and pigs. For instance, the dog insurance covers all kinds of dogs including exotic dogs, from 8-weekolds to 8-year-olds. It covers death due to accident, illness, poisoning, permanent disability, liability of personal injury or property damage. The insurance has add-on benefits that can cover lost or stolen dogs and breeding risk amongst others.

Buying the insurance requires a proposal form to be filled, veterinary health certificate providing unique identification through a tattoo or nose print. The sum insured in such policies is the replacement cost of the dog, and the premium is around 5% of the sum insured.

Insurance companies usually bear 80% of the sum insured (market value certified by a veterinary doctor) and 20% is borne by the owner or parent of the pet. Most of the policies currently available cover replacement costs, but not care and wellness-related expenses, largely due to the lack of a big market, and also an organised network of healthcare providers.

What next?

With growing number of pets and launch of organised healthcare service providers, upcoming pet insurance policies will be able to provide seamless comprehensive solutions on a cashless basis. Such policies will cover expenses related to illnesses, injuries, liability and wellness , such as doctor visits, surgeries, vaccinations, spaying or neutering, third party covers and discounted services to pet spas.

The risks covered under a dog insurance plan vary from insurer to insurer. Very recently, Digit Insurance in association with a pet supply distributor Vetina launched a pet insurance product. It currently covers only dogs and gives protection against major illness, accidental injury and third party covers.Pet insurance solutions of the future should be able to help find the right treatment, doctor and institution, cover the routine and major healthcare expenses — whether they require hospitalisation or not.

As welcoming a pet to the family entails a lot of cost and responsibility, it is best to get it insured when it is young. While getting an insurance policy for the new member, do look at every detail, know about all the exclusions and the claims process. You will find them complex with a lot of problems. These of course should get resolved in the coming years.

(Mahavir Chopra is director health, life and travel insurance, Coverfox.com)

TOP

Source

PENSION

NPS annuity is not going away anytime soon: PFRDA Chairman EXCLUSIVE – Financial Express – 13th February 2019

While PFRDA has worked to promote its flagship National Pension Scheme since its inception in 2009, Hemant G Contractor, Chairman, Pension Fund Regulatory Development Authority, says that there are still miles to go as the NPS subscriber base is yet miles away from the desired number.

Contractor attributes this to the lack of financial awareness among people while stressing the need to have a pension plan considering growing life expectancy.

In a recent interview with Financial Express Online, Hemant Contractor spoke about various issues ailing the smooth growth of the National Pension Scheme. He discusses PFRDA's future plans and challenges. He also answers why the annuity component in the withdrawal of NPS corpus may not be going away any sooner.

Here are the edited excerpts of PFRDA Chairman Hemant Contractor's conversation with Prachi Gupta and Shaleen Agrawal.

How has your experience been in PFRDA since joining it in 2014?
Since I come from the banking background, pension policy was an interesting and a new change. When I joined, it was in its nascent stage. In the four years that followed, the growth has been good. Nevertheless, there is so much yet to be done as so many people still are not on-board the pension plan.

Why are Indians hesitant to join the National Pension Scheme?
The NPS plan is voluntary and it takes persuasion for people to actually make such a long time commitment. It has not been easy to sell the scheme since the needs of the people are immediate. Financial literacy among people is low, pension literacy is lower. People don't understand the importance of enrolling for a pension scheme. What escapes people is that the average lifespan has increased and hence more and more people should have a pension cover. Also, the income-levels in non-organised sectors are low which results in constrained participation.

Which sectors remain largely untouched by the NPS?
People in the organised sectors, government employees, and well-off people are well covered by the plan. However, those employed in the non-organised sector and the ones who are not doing well financially remain largely untouched.

What has been the response in general towards the pension plans?
We got a generally good response to Atal Pension Yojana which was launched as a replacement to previous Swavalamban Yojana. We are touching 1.5 crore subscribers, with a total corpus of about Rs 2, 95,000 crore.

NPS comes off as a very complicated scheme even to well-educated people. The annuity is a complicated concept. Is there a scope to simplify it?
NPS does require some explanation and educating people about the same is a major challenge to us. The irony is that annuity is provided by the insurance company. The issue here is that we undertake only the accumulation part of the policy. Had we provided the annuity, it would have been in one package.

Do you think that the 40% of the corpus getting locked up in annuity is a deterrent in people signing up for NPS?
I understand that annuity has a lot of drawbacks. People don't like the idea of it. However, the appealing part of the annuity is you get an assured payment which is a source of comfort for so many people. People need to have something to fall back on in their retirement years.

Can we expect to do away with the annuity component?
Annuity is not going anywhere; however, there can be some improvements. If it were left to the people, they would rather have 100% salary drawn at the end and splurge it all together. We don't want that to happen. We want them to have something instead of falling back on their children.

Will the changes proposed to the NPS be applicable to old-subscribers as well?
No. Only to new subscribers. We have proposed a few major changes. First, the government contribution is to rise from the previous 10%. Secondly, government employees will be able to decide whom to place the money with. This is for the new-flow. However, for those who wish to get enrolled in the new scheme, they will have a provision to convert to the same.

Do you think that the period between the old scheme and the new scheme will see a slowdown in the subscription?
A slowdown hits us if we are not doing well. We are doing well already. But once the scheme is announced, we will be better off.

What are your current challenges?
We really need to improve the awareness level among people. Currently, we are way off our NPS target. We need cooperation from more tax-payers as it benefits everyone. Also, we are trying to get annuity tax-free. Greater support from government is also needed as we have suggested few changes to the Atal Pension Yojana.

What are PFRDA's future plans?
We aim to add 50 lakh additional subscribers to Atal Pension Yojana. While NPS is growing by 30-40% by year, it is also gaining popularity. We look forward to having more people in it.

TOP

Source

Govt's new pension scheme seen adding to subscribers' confusion – Mint – 11th February 2019

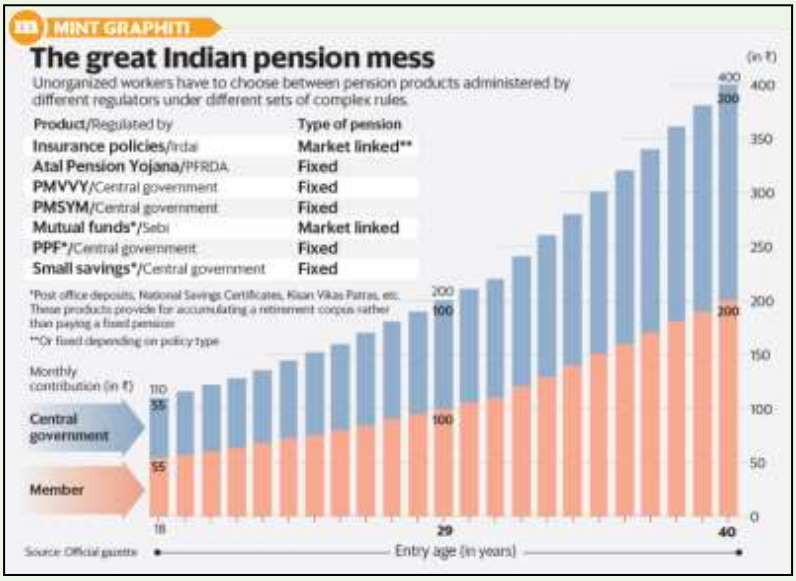
The government on 7 February notified rules for the Pradhan Mantri Shram Yogi Maan-Dhan (PMSYM) scheme, which was announced in interim budget 2019-20 as a pension scheme for the unorganized sector workers.

PMSYM promises a pension of Rs3,000 per month when the subscribers turns 60, in return for fixed monthly contributions starting for as little as Rs55. Unorganized sector workers between 18 and 40 years, and earning up to Rs15,000 per month can join the scheme, which will be launched on 15 February. A slew of conditions and exclusions have, however, been specified, making it a difficult selling proposition. There is little to distinguish it from the existing Atal Pension Yojana (APY) and, in many ways, it is a step backward from APY. Subscribers can, in theory, be part of both schemes, but this only adds to the complexity of the system.

Unorganized sector workers in India can choose between life insurance policies (including Life Insurance Corporation of India policies), PMVVY (Pradhan Mantri Vaya Vandana Yojana), APY and now PMSYM, in order to secure a pension for themselves. They also have the choice of saving their money in Public Provident Fund, mutual funds and small savings schemes such as National Savings Certificates (NSCs) and Kisan Vikas Patras (KVPs). However, these products provide for retirement corpus growth rather than a monthly pension. We have excluded the Employees' Pension Scheme (EPS) under the EPF Act, 1952, from this list because it applies to organized sector workers.

What is PMSYM?
It is a pension scheme targeted at unorganized sector workers aged 18-40, who are not covered by EPS or centre's National Pension System, and who are not income-tax assesses. Such workers will get a monthly pension of Rs3,000 after they reach 60. In return they have to make monthly contributions of a specified amount which varies according to their age. At 18 years, it will be as low as Rs55 per month and will be matched by an equal contribution from the central government.

An inferior cousin of APY
The PMSYM structure is almost identical to APY which also gives a guaranteed minimum pension of Rs1,000-5,000 in return for a fixed schedule of contributions. APY is also for people between the ages of 18 and 40, and provides a pension from age 60. However, in other key respects, PMSYM is actually an inferior product. First, APY provides pension ranging from Rs1,000-5,000 per month, while the PMSYM pension is capped at just Rs3,000 per month. This amount, which is already quite low, is likely to be



further eroded by inflation over time. Second, PMSYM is only open to those with monthly income of up to Rs15,000, whereas APY contains no such income limit. The limit of Rs15,000 is also incongruous given that Employees' Provident Fund Organisation is considering increasing the Rs15,000 salary limit for calculating pension under EPS. Third, in APY, you can choose to contribute monthly, quarterly or half yearly, which is of great help to those in the unorganized sector with irregular income. PMSYM only allows monthly contributions. Fourth, APY provides for return of corpus on the death of the subscriber and his spouse. In PMSYM, workers only get a pension and do not accumulate a corpus for their family. On the death of the worker and his/her spouse, the corpus is forfeited to PMSYM. Fifth, it will be directly managed by the government unlike APY, which is regulated by the Pension Fund Regulatory and Development Authority (PFRDA).

There is only one parameter on which PMSYM scores over APY. It provides for equal government co-contributions to all subscribers. This brings down the amount needed from the subscriber's pocket. APY also provides for government co-contributions, but only for those who joined before 31 March 2016, and who were not taxpayers, or beneficiaries of any other social security. As a result, the monthly contribution at age 30 in PMSYM is Rs55 against Rs126 in APY. However, the two cannot strictly be compared because APY provides for return of the accumulated corpus to the subscriber's family, while the accumulated corpus is forfeited to PMSYM fund.

Why introduce PMSYM?

PMSYM is all set to come under the labour ministry. In APY, each subscriber's contributions are maintained in a separate account against a unique number (Permanent Retirement Account Number). No such system has been set up for PMSYM, bringing it directly under government control. Official have indicated that this may have been an outcome of a turf war between the labour ministry and PFRDA.

TOP

Source

Pension scheme trial today as government plans Feb 15 launch - Hindustan Times – 11th February 2019

Prime Minister Narendra Modi will likely launch the government's new pension scheme for unorganised sector workers on February 15 and a trial run of the software of the new scheme is slated for Monday, a top government official said on condition of anonymity.

The scheme will be administered by the Life Insurance Corporation of India, the official said, adding that he and other officials are awaiting a confirmation of the launch date from the Prime Minister's Office.

The new scheme promises marginally higher benefits compared to its predecessor, the Atal Pension Yojana, but that may not result in the informal sector workers making a dash for it in substantially higher numbers, analysts say.

The Atal Pension Yojana, launched in June 2015, had a target of 20 million subscribers by the end of 2015. By mid-2018, it had 11 million subscribers, according to official data. India's so-called informal sector employs about 420 million people, according to Census 2011, and accounts for half of the country's gross domestic product (GDP). Unorganised sector jobs don't come with any form of social security, such as retirement benefits. The much smaller formal economy employs only 50 million.

The Pradhan Mantri Shram Yogi Maandhan (PMSYM) announced in the interim budget promises unorganised sector workers earning up to Rs 15,000 a month a monthly pension of Rs 3,000 after they attain the age of 60. Workers between the ages of 18 and 40 years qualify for the scheme. In his speech, finance minister Piyush Goyal said the scheme will cater to 100 million people.

On the face, this works out to be a better deal compared to the older scheme because a worker will now have to shell out less for exactly similar payouts, or benefits. A worker who joins the new scheme at the age of 18 will have to contribute Rs 55 a month and a matching amount will be contributed by the government. Those above 29 years will have to contribute Rs 100 every month (to make up for late entry, which reduces the total lifetime contribution).

As an illustrative case, economist Amitabh Kundu says that earlier for a Rs 1,000 monthly pension, a worker entering the scheme at the age of 18 had to contribute Rs 42 every month. So, for a Rs 3,000 pension a month (which is what the new scheme offers), a worker would have had to deposit Rs 126 (Rs 42 a month multiplied by 3). But analysts say some of the "disincentives" for poor workers in the erstwhile scheme still show up in the new scheme.

"Yes, the government is giving something for sure. I am not criticizing the government on that count at all. But what is the interest rate being offered? Will it be an incentive enough?" asked Kundu, who has devised many welfare schemes. Kundu has been a member of the National Statistical Commission, evaluated minority welfare policies, headed a panel on affordable housing, and was most recently tasked with evaluating Swachh Bharat Abhiyaan (rural), the cleanliness-cum-sanitation programme launched by Modi in 2014.

In the earlier scheme, the interest rate — or rate of return — was about 7.5%. In the new scheme, the rate of return will be determined by the Insurance Regulatory Development Authority, the official cited in the first instance said.

"So, the crux is that for the formal sector, if the interest rate on provident fund is about 8.55%, at least give that much in the case of informal workers too to make the scheme attractive," Kundu said. "Even the threshold of Rs 15,000 [employees earning more don't qualify for the new scheme] is problematic to me," said KR Shyam Sundar of XLRI, Jamshedpur.

Those earning Rs 15,000 fall in the lower middle-class. But those earning much less, say Rs 3000 a month, will not be keen on parting with anything from their meagre incomes. Their share of contribution should be waived off to expand enrolment, Sundar said.

Like in the old scheme, anyone older than 40 is ineligible for the new scheme. The share of the workforce above 40 years is over 30% as per the 2011 Census. Extrapolating this, 30% of 420 million informal workforce comes to 126 million people. A second government official said that when seen in conjunction with other welfare programmers, the National Democratic Alliance (NDA) government has come up with a comprehensive safety net for the poor.

He explained that the poor could also count on the Ayushman Bharat for health protection, PM Jeevan Jyothi Bima Yojana, a completely free life insurance scheme, and also PM Suraksha Yojana for accidental death. "So, this is complete package of social security for the poor."

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Source

IRDAI CIRCULAR

IRDAI issued notification regarding IRDAI (Insurance Brokers) (First Amendment) Regulations, 2018.

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Source

First year premium of life insurers for the period ended 31st January, 2019 is available on IRDAI website.

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Source

Insurer wise list of life insurance products launched / modified in the financial year 2018 - 19 is available on IRDAI website.

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Source

List of insurance marketing firms as on 31.01.2019 is available on IRDAI website.

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Source

GLOBAL NEWS

New Zealand: Law amended to increase quake coverage – Asia Insurance Review

Lawmakers have passed changes to the Earthquake Commission (EQC) Act which will increase the quake coverage cap on new claims from NZ$100,000 ($68,300) to NZ$150,000 and remove cover for home contents as homeowner's policies are taken out or renewed over the 12 months from 1 July 2019.

The changes were announced by the Minister Responsible for the EQC, Dr Megan Woods who said, "Increasing the cap EQC can pay on new claims to NZ$150,000, from NZ$100,000, recognises the increase in building costs and means less over-cap claims will need to be passed onto private insurers.

"We have also removed EQC cover for contents and personal property, which will be picked up by private insurers. Removing cover for contents will focus all EQC's claim management resources on resolving residential building and land damage claims."

To sum up, the four key changes to the law that would be phased in over the next 12 months are:

- An increase in the cap on EQC residential building cover to NZ$150,000 from July 2019;
- Removal of the NZ$20,000 EQ Cover for contents from July 2019;
- An immediate extension of the timeframe for lodging a claim from three months to two years; and
- Providing EQC scope to share information as necessary to settle insurance claims.

The EQC Act has been under review since 2012 as successive governments have considered changes to natural disaster insurance arrangements and the management of risk and recovery in New Zealand.

"The review, and the changes that have been announced, have looked at the lessons, not only from the Canterbury earthquakes but other events since the current Earthquake Commission Act was enacted in 1993," said EQC chief executive, Sid Miller.

"Along with these policy changes, we have also introduced a range of operational and organisation changes since 2017 to improve our claim management processes and customer experience." Existing claims will not be affected by the amendments, as the current NZ$100,000 cap still applies to them.

Info sharing

Commenting on more information sharing following the changes, Dr Woods said, "Previously homeowners and prospective buyers could only get information about claims on a property where there was a deed of assignment from the former owner. This meant people couldn't find out what EQC claims there had been on a property they owned or were looking to buy. People should still get a deed of assignment when buying a house, but this change helps people who don't have one.

"The changes we have made also allow EQC to share information to prevent or lessen a threat to public health or safety."

The amendment defines property-related information as information about natural disaster damage to a residential property (dwelling and land) and any claims made under the Earthquake Commission Act. It also covers information about the assessed cost of replacing or reinstating damaged property, repair work that has been carried out and settlement amounts.

The EQC administers the New Zealand Natural Disaster Fund (NDF) which receives monies directly passed on by private insurers, from a flat rate levy imposed on all households who purchase a homeowner insurance policy. The EQC is also responsible for investing the fund and ensuring there is adequate reinsurance cover available.

Mr Tim Grafton, CEO of the Insurance Council of New Zealand, says insurers are supportive of the long-expected changes, including the cap increase. "Generally we see this as a good move," he said. "Over time the value of a loss will have increased." He adds that greater information sharing will be helpful.

TOP

Source

Philippines: Regulator imposes "cooling off" period for health insurance purchases - Asia Insurance Review

The Insurance Commission (IC) has directed all health insurers and health maintenance organisations (HMOs) to provide a "free-look" period for health insurance policies and health maintenance contracts.

In a statement, Insurance Commissioner Dennis B. Funa said insurance companies must allow a five-day free-look period for health insurance policies covering six months or less, while 15 days must be given to coverage of over half a year.

The Insurance Commission defined the free-look period as "time in which a new health insurance policy owner can terminate or cancel the insurance policy."

"A free-look period allows the policyholder to decide whether or not to continue with the contract, and if he or she decides to cancel it for whatever reason/s, the policyholder can demand the cancellation thereof… It is that window of time given to policyholders to read the policy provisions, understand the inclusions and exclusions, and if he or she has purchased the right product," MrFuna explained.

The free-look period starts as soon as the policyholder receives the health insurance contract. "If an insured decides to cancel or surrender the policy within the free-look period, he or she shall be entitled to the return of all premiums paid," Mr.Funa said. As for health maintenance organisations (HMOs), Funa also ordered them to "incorporate a similar free-look period in all health maintenance contracts".

TOP

Source

China: More Chinese buy travel insurance as their tourist numbers rise - Asia Insurance Review

The number of Chinese travellers who bought travel accident insurance for outbound trips has jumped nearly 20% year-on-year, according to a report by Ctrip.com International, China's largest online travel agency by revenue. One reason for the growth is that more Chinese are travelling. An estimated 156m Chinese travelled overseas last year, compared to 145m in 2017.

In terms of payouts, 46% of money went to compensating travel schedule changes, 35% was for travel delays, and 15% for medical care costs, reported *China Daily* citing the Ctrip report. No absolute numbers were provided for travel insurance buyers and payouts made.

The report found overseas trips to be more risky than domestic trips. Some long-distance overseas destinations, such as the US, Canada, New Zealand, as well as tropical islands, saw higher actual risk probabilities.

Tourists often experienced robberies, tour booking frauds, traffic accidents, and yachting mishaps, especially in some countries such as Thailand, which are notorious for such incidents, said Huize, China's largest third-party insurance platform.

Chile, France and Spain are also destinations that frequently see robbery cases, and travellers to the US have reported cases of harm to property and personal safety incidents, Huize found.

Flight delays, the most frequent kind of unexpected travel changes, happened most often in Guangzhou of Guangdong province, Xiamen of Fujian province, and Hainan province in China. While among foreign countries, Indonesia (Bali Island), the Maldives and the Philippines top the list.

Europe had the highest proportion of Chinese tourists with travel insurance, helped by the fact that travellers need insurance when applying for a Schengen Visa. The region is followed by Sri Lanka, New Zealand and Indonesia, according to Ctrip.

In China, areas with high altitudes, relatively worse transportation and difficult environmental conditions, such as Qinghai province, Shanxi province, and Inner Mongolia autonomous region, saw a higher proportion of travellers purchasing insurance.

One prime reason is cost. In some countries, emergency medical care services for uncovered patients can be as much 30 times more expensive than China, with the US, Canada, Europe, Japan, Australia and New Zealand all noted for their high fees.

Meanwhile, the increase in China's senior population is also being felt in the travel market. Not only are older people travelling more, they are also claiming more from insurers after mishaps.

Trips and falls make up the largest proportion of medical claims. More than half of travellers who fall are middle-aged and senior people, with hotel bathrooms, queues, and mountain paths being the most likely places where mishaps happen.

More than 50% of travellers now complete the compensation process by themselves on their smartphones.

Around 145m Chinese tourists travelled overseas in 2017, compared to 137m in 2016. The annual number of Chinese travellers holidaying overseas is forecast to continue to grow to 400m by 2030.

TOP

Source

Singapore: Life sector posts 3% growth in new business in 2018 - Asia Insurance Review

Singapore's life insurance industry recorded a 3% growth in new business premiums in 2018 compared to the previous year, supported by the continued uptake of annual premium policies.

Annual premium policies grew by 6% from the previous year, accounting for S$2.78bn ($2.05bn) out of $4.2bn of total new business premiums for 2018.

Single premium plans however, recorded a dip in sales of 3% compared to 2017. The slowdown is attributed to turbulent markets late last year and new regulations requiring the sales charge for the purchases of CPF Investment Scheme (CPFIS) products to be halved from 3% to 1.5%. This change took effect on 1 October 2018.

While the volatility of end 2018, coupled with global trade tensions, resulted in a 28% drop in single premium plan sales, LIA Singapore said that changes to the regulations surrounding sales of CPFIS products also had a significant impact. The last quarter of 2018 saw single premium CPFIS-included products record S$29mn in weighted premiums, 62% less than the previous quester.

At the same time, there was continued demand for protection products and health coverage, with an increase in purchase of retirement policies. The uptake of retirement policies designed to provide regular payouts to policyholders during their retirement years saw a significant increase of 48%, with 38,120 policies being purchased in 2018 compared to the previous year.

Mr Patrick Teow, president of LIA Singapore said that Singapore's life insurance industry managed to achieve growth despite a challenging end to 2018. Looking forward, Mr. Teow said, "As we remain alert to the repercussions of continuing trade frictions and geo-political challenges, I am confident that life insurers will demonstrate agility and resilience by adapting to the changing environment to deliver solutions to meet Singaporeans' insurance, investment and savings needs."

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Source