भारतीय बीमा संस्थान
INSURANCE INSTITUTE OF INDIA

# INSUNEWS

**Weekly e-Newsletter**

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## QUOTE OF THE WEEK

**"Do not dwell in the past; do not dream of the future, concentrate the mind on the present moment."**

**- Buddha**

## INSIDE THE ISSUE

## INSURANCE TERM FOR THE WEEK

### *Insurance Bonus*

'Bonus' in insurance parlance refers to the benefit over and above the cover and the maturity amount. There are broadly three types — reversionary bonus, loyalty bonus and terminal bonus.

Terminal bonus is the benefit offered by insurers when the policy matures in both ULIPs and traditional policies. Loyalty bonus is given to policyholders who stay for a term of 10 or more years. Endowment policies as well as ULIPs offer this bonus.

Reversionary bonus is given only in life policies, where there is an investment-insurance combo. It is declared as a percentage of sum assured.

The amount of bonus, until declared, is not guaranteed. The bonus declaration every year is a decision made by the company's board based on the amount of profits (surplus) for the year. The bonus is paid along with the sum assured (on death) or with the maturity amount at the end of the policy tenure.

**Source**

## INSURANCE INDUSTRY

### *Never sign your insurance application blindly, may face problems realising claims – Financial Express – 18th February 2019*

An insurance policy provides you peace of mind under adverse situations by providing you and your loved ones financial support in adverse situations. However, your adversities may compound if your insurance company were to reject your claim due to the contents of the application form you had filed while buying your policy.

You may face such serious situations especially if you sign the application blindly without reading the policy fine print – or worse, if you allow someone else to fill up your form.

**Knowing what's covered**

An average person requires various forms of insurance to cover a broad range of risks. For example, to ensure financial safety of your family against your death risk, you need a life insurance policy. To meet the high costs of hospitalization, you need health insurance. Therefore, it's important you know if your risks are covered by the policy you're buying. If you blindly pick a policy without knowing of its benefits, inclusions, and exclusions, you're risking claim rejection. The insurance marketplace has a wide variety of options, and each product is created differently with its own distinctive features and limitations.

**Making correct declarations**

Insurance application requires every detail to be mentioned correctly. It's common to share information like age, gender, health condition, smoking habits, pre-existing diseases, past claims etc. in your form. If you provide incorrect information about yourself, you may have problems making claims. For example, if you fail to declare you're a smoker and later seek hospitalisation for an ailment caused by tobacco, you may experience problems making your claim.

**Read and enquire**

When you have the policy application in your hand, ensure that you've read it carefully. Ideally, you should also read the product brochure of the policy you're buying because your family's finances will depend on this policy. Often, insurance salesmen provide you the form and indicate where you need to sign. You get the feeling that you're being rushed through the purchase process. Some salesmen may even tell you to just sign and leave the rest of the form filling to them. This is dangerous. Ensure you've filled the form yourself. If you're in doubt about any feature, ask questions. Sign only once you're convinced that the product is the right one for you.

**What should you check for?**

The policy fine print will consist of critical information on the extent of the cover. For example, the policy may list the illnesses for which day-care treatment is covered, or the waiting period for the treatment of another list of illnesses, or a list of diseases that the policy will not cover. Also, exclusions can be temporary or permanent.

Next, you should check the sub-limits – caps on coverage – on the treatment of certain disease, room rent, etc. There's also the matter of pre-and post-hospitalisation costs. Sub-limits and pre/post-hospitalisation costs vary from one policy to another. But reading the brochure and application will help you be clear on whether the coverage is enough for you or not. Insufficient coverage may lead you to having to part-pay hospitalisation costs from your own pocket.

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**Source**

## IRDAI REGULATION

### *Insurers asked to focus on governance - The Asian Age – 22nd February 2019*


In the backdrop of the IL&FS scam that rattled the country's financial institutions, the Insurance Regulatory and Development Authority of India (IRDAI) has cautioned insurance players about the need to be diligent on corporate governance in the sector.

IRDAI chairman Subhash Chandra Khuntia held a high-level meeting this week, in which all chiefs of insurance companies in India—both life and non-life insurers—were told to personally oversee board decisions of their companies to ensure that governance norms were not compromised.

A top IRDAI source told Financial Chronicle that the meeting was held in Hyderabad on February 19 and it was attended by 26 chairmen of both life and non-life insurance companies. "The chairmen of GIC Re and Agriculture Insurance Company were not invited to the meeting, as they are not directly involved in the commercial transaction in their businesses," the source said on condition of anonymity.

When asked about the important issues that discussed in the meeting, the source said, "The issues involved in corporate governance were discussed, but the main focus of the discussion was the IL&FS fallout and its mismanagement and corporate governance violations."

"Besides, the corporate issues like falling solvency margin, which indicates the financial health of an insurance company, risk-based capital and fair-value advantage were also discussed during the meeting. Apart from that concern was also expressed that how some of the insurers are constantly incurring underwriting losses," the source added.

The high-level meeting was the first of its kind. "This was the first time that such a forum for open discussions between chairpersons of insurers and IRDAI was held. It was a proactive exchange of thoughts, suggestions and ideas and I hope some of these will get implemented in the coming months," said the chief of a private insurer.

As of March 2018, IL&FS owed over Rs 94,000-crore to banks and other creditors and has been downgraded to junk status by rating agencies after it defaulted on debt repayments due to a liquidity crisis. Last year, the government also constituted a seven-member board, headed by veteran banker Uday Kotak, to submit a comprehensive resolution plan to revive the debt-ridden company.

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Source

## *Why reinsurance has attracted IRDA scrutiny – Mint – 20th February 2019*

The Insurance Regulatory and Development Authority of India (IRDA) has issued an advisory to non-life insurance companies asking them to carry out proper due diligence when they enter into reinsurance contracts through brokers. *Mint* tells you why.

**What prompted IRDA to issue an advisory?**

An insurance firm that employed the services of a broker to reinsure its business through overseas reinsurers recently realized that the broker hadn't placed the business with the reinsurance companies, according to some insurers and brokers.

This prompted IRDA to issue an advisory asking non-life insurance firms to be vigilant while taking reinsurance cover from overseas. An IRDA official said the advisory was issued to ensure that insurance firms carry out proper due diligence when they contract reinsurance through an intermediary and that they vet and cross-check reinsurance contracts.

**Why do insurers need reinsurance?**

Just as people take insurance cover to ensure mishaps don't cause a financial dent in their lives, insurance firms, though they are in the business of paying insurance claims, need to insure themselves to ensure that a catastrophic event doesn't leave them bankrupt. As such, insurance firms reinsure themselves to ensure they are able to pay claims even in catastrophic events.

Being reinsured also means that insurance companies can insure newer or much larger risks. However, just as people employ the services of a broker to get insurance cover, insurance companies employ the services of an intermediary for reinsurance.

**What are the rules regarding reinsurance?**

Non-life insurance firms have to reinsure 5% of their portfolio with GIC. They do this by ceding 5% of their gross written premiums to the reinsurer, which then insures the risk in the same share.

**Can insurers reinsure beyond 5%?**

Insurers have to reinsure at least 5% of their business. This is called obligatory insurance. Voluntarily, they can exceed 5%. Some insurers say the tendency is to go beyond the obligatory limit, especially in the case of corporate fire and marine insurance due to the large size of the risk.

Insurers can also reinsure themselves through a reinsurance firm operating in India or abroad. About 10 overseas reinsurance firms operate in India. Insurance firms can also tap overseas reinsurance companies, though this is subject to limits.

**Does reinsurance ease capital pressure?**
It does to an extent. IRDA mandates insurers to maintain a minimum solvency margin—the margin of assets a company owns over its liabilities. It is thus a measure of how much premium the company underwrites.

If the firm cedes a greater portion of risk to the reinsurer, it is able to maintain IRDA's requirement of minimum solvency ratio with less capital. Insurers are thus able to ease capital pressure while maintaining the solvency ratio. This is akin to financial reinsurance, a practice not encouraged by the regulator.

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**Source**

## *Standard mediclaim policy on the cards, guidelines to be framed – The Hindu – 19th February 2019*


The Insurance Regulatory and Development Authority of India (IRDAI) has set in motion the process of formulating guidelines for a Standard Health Product that it wants all general and health insurance companies to offer.

The Standard Mediclaim Policy, followed by the name of the insurer concerned, as the product would be called, will have a minimum basic sum insured of Rs 50,000 and a maximum limit of Rs 10 lakh.

It will be for those above 18 years of age with the maximum age at entry of 65 years. With health products differing significantly in terms of their benefits, it is essential that potential customers need to have access to a basic health insurance cover. This would enable them to choose the coverage based on the need, IRDAI said, inviting suggestions from stakeholders on the draft guidelines.

Such a policy, it said, was necessary as at times the prospective customers may have no option but to choose a health product which has embedded certain other covers whether or not such covers are needed. Dependent child/children aged upto 25 years are to be covered under the policy.

On the benefit structure, the regulator mooted a 'Base Cover' comprising various, mandatory components under hospitalisation expenses. These include ICU/ICCU expenses; cost incurred on treatment of cataract subject to certain limits; dental treatment, necessitated due to an injury; and plastic surgery, necessitated due to disease or injury. IRDAI wanted the companies to devise a pricing mechanism that incentivised early entry of prospective policyholders, continued renewals and favourable claim experience.

Expenses incurred on treatment under Ayurveda, Unani, Siddha and Homeopathy (AYUSH) systems of medicines would be covered as well as those on pre and post hospitalisation medical expenses subject to certain conditions, the proposed guideline said. Wellness incentives are to be offered as part of the proposed policy.

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**Source**

## *Set up core 'sandbox committee' to promote digital innovations: Irdai panel – The Times of India – 17th February 2019*

An expert panel has suggested to insurance regulator IRDAI to set up a core 'Sandbox Committee' to promote digital innovation in the sector while safeguarding the interest of policyholders.

Loosely defined, a sandbox approach means experimenting and learning before finally adopting a technology or system. This approach helps in containing the impact of failures.

The Insurance Regulatory and Development Authority of India (IRDAI) had set up the 10-member expert panel to come out with a consultation paper on regulatory sandbox approach to enable testing of products in a controlled environment so that the industry could keep pace with the fast-evolving financial technology (fintech).


"IRDAI should create a core Sandbox Committee having dedicated personnel to monitor and supervise the digital innovation activities, and provide support and advisory to the applicants as envisaged in the draft guidelines," said the report of the expert panel. The core sandbox committee would facilitate rollout of the experiments and seek to provide the ecosystem required for the experimentation.

The purpose of the regulatory sandbox is to foster growth and increase the pace of the most innovative companies, in a way that provides InsurTech (technology-led insurance firms) in particular and the fintech sector as a whole with flexibility in dealing with regulatory requirements and at the same time focussing on policyholder protection, the report said.

"Regulatory sandboxing will be instrumental in providing a safe environment for fintech solutions to experiment and flourish in, given the fact that they would have enough time to lay down the necessary groundwork," said Rohan Kumar, Co-founder and CEO of Toffee Insurance, an all-digital InsurTech company.

Further, it will assist new technologies to emerge and ease into the highly regulated Indian market, he added. A separate working group set up by IRDAI has already examined various aspects of InsurTech and made certain recommendations in this regard. One of the recommendations was setting up a sandbox environment within IRDAI in order to encourage InsurTech innovations that help increase insurance penetration as well as seek to benefit policyholders at large.

The report further said the proposed regulatory sandbox would have defined entry and eligibility criteria, boundary conditions, process flow, timelines and success factors/ exit parameters for the applicants, along with appropriate controls for protection and risk management. The objective of the regulatory sandbox is to facilitate innovations in the insurance sector, make the products more affordable and relevant for the insured and to give a fillip to insurance penetration.
IRDAI has sought comments on the consultation paper till February 26.

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**Source**

## LIFE INSURANCE

### *Life Insurance: Urban Indians grossly underprotected - The Hindu Business Line – 20th February 2019*

In what is seen as a reflection of India's dismal level of protection coverage, a new survey has revealed that just one-third of urban Indians feel protected, though two-thirds own insurance. The survey – put out by Max Life Insurance and Kantar IMRB – has revealed that urban India stands at a protection quotient of 35 in the first-ever India Protection Quotient (IPQ), which measures the degree at which Indians feel protected from future uncertainties on a scale of 0 to 100.

This proprietary tool has been developed for assessing how protected urban India is. It is based on the attitudes, mental preparedness around future uncertainties, awareness, and ownership of life insurance product categories (term, endowment and ULIP).


With a sample size of 4,566 respondents, the survey was administered on respondents of different demographics and age groups (25 to 55 years) across 15 metropolitan and Tier-I cities in India. Decision makers/influencers, with an annual household income of Rs 2 lakh or more, were covered.

Prashant Tripathy, Managing Director and CEO, Max Life Insurance, said: "This survey reveals some interesting and startling findings about the state of protection in the country as well as the attitude, behaviour and apprehensions that people have around life insurance."

Term insurance, despite being the most fundamental and cheapest form of financial protection, still lacks a significant uptake in urban India, he said.

"There is an urgent need for Indians to understand the true value of protecting one's family from the uncertainties of life. We hope the results of this study act as a wake-up call for consumers and the industry at large and help increase financial protection in the country," he said.

Tripathy said the IPQ effort, which is going to be an annual exercise, should not be seen as one intended to drive sales of Max Life Insurance. "The objective is to get a good understanding of the ground level situation and create roadmap to address it."

The low score of 35 will now be a reference frame for the progress that will be made in addressing the protection gap in the country.

**Millennials**

The survey findings reveal millennials in India are not keen on preparing themselves for tomorrow, but want to priortise on spending on travel and luxury.

Working Women in India are grossly under-protected. They don't consider themselves as breadwinners, have low IPQ and low life and term insurance ownership, the survey revealed.

***TOP***

**Source**

## *Raising Rs 1 crore for daughter: Sukanya Samriddhi or ULIP or mutual funds? Must know facts – Financial Express – 16th February 2019*

With the rising cost of living as well that of education, marriage etc, making proper investments is a matter of concern for most of the parents to make funds available to meet the financial goals for their daughter(s) as and when required.

Before choosing an investment plan, therefore, parents must take into consideration the effect of inflation, which may increase the current cost many-folds, resulting in a higher fund requirement in the future.

Assuming that the requirement of Rs 1 crore has been calculated keeping in mind the effect of inflation and also the time when the girl turns 21-year old, let's evaluate the three investment options and the amount to be invested periodically to achieve the target on time.

**Sukanya Samriddhi Yojana (SSY)**
Among the several investment avenues to reach the goal, SSY has become a very popular choice due to attractive interest rate, complete tax benefits and sovereign guarantee. However, there is a limit on investments per financial year, which is currently Rs 1,50,000. If the current interest rate of 8.5 per cent and investments as per the limit continue and the parent of a daughter starts investing from the year of the birth of the girl, the maximum Rs 74,96,802 would be accumulated in the SSY account at the end of 21 years, if Rs 1,50,000 is invested at the beginning of every year for 15 years.

So, SSY alone won't be sufficient to accumulate Rs 1 core in 21 years. Moreover, as the age of the girl increases, lesser will be the return till the age of 10, as an SSY account may be opened for a girl child till she turns 10 years old.

**Unit-linked Insurance Plan (ULIP)**
Along with insurance, ULIPs also provide an investment option through the equity route. While the insurance part ensures additional security, equity investments bear the market risks, but generate higher return over the long term. ULIP investments are also completely tax-free.

Assuming that ULIPs take the conservative route generating about 9 per cent long-term compound annual growth rate (CAGR), about Rs 15,541 need to be invested at the beginning of every month (i.e. about Rs 1,86,493 every year) for 20 years starting from the year of birth of the girl.

**Mutual Fund (MF)**
Investments in MFs are subject to market risk depending on the category of a fund, but generate higher returns than other investment options over the long term. Investments in equity-linked saving schemes (i.e. ELSS category of MFs) enjoy tax deductions u/s 80C, while other categories don't enjoy such benefit. Moreover, from this year, 10 per cent long-term capital gain (LTCG) tax has been imposed on equity MFs over the LTCG of Rs 1 lakh on redemptions made in a financial year. The gains from MFs are considered long term, if redemption is made after one year from the date of investment.

Assuming long-term CAGR of 12 per cent, a person has to start a monthly SIP of about Rs 10,871 (i.e. about Rs 1,30,455 per year) for 20 years to accumulate a corpus of Rs 1 crore (without considering the LTCG tax of approximately Rs 7.29 lakh).

***TOP***

**Source**

## GENERAL INSURANCE

### *PSU general insurers are suffering due to govt's negligence - National Herald – 19th February 2019*


The good news is that the non-life insurance industry has crossed the mark of Rs 1.39 trillion as on January-end, showing a positive sign towards the growth. If the growth story continues like this, then the industry is all set to clock the current fiscal at Rs 1.7 trillion from Rs 1.5 trillion as had been achieved by the industry in the last fiscal.

However, there is a flip side to the growth industry. The industry's growth this time is driven by private sector players as their state-owned peers have shown negative growth during the period under review.

The industry has crossed Rs 1.39 trillion in April-January from Rs 1.23 trillion in the year-ago period, showing a business growth of 13%.

State-owned general insurer New India Assurance, which is the country's largest non-life insurer with a market share at 14.24%, also showed a negative growth in the month of January, as its business fell by 14% to Rs 1,708 crore from Rs 1,986 crore a year ago. It is despite the fact that the company has shown a positive growth in the 10-month period as its business grew by 5% to Rs 1,9810 crore during the period from Rs 1,8792 crore a year ago.

Among the remaining three state-owned general insurers, Oriental Insurance Company (8%) and United India Insurance (2%) have shown positive growth in January, whereas National Insurance Company's business has dipped by 36% in the month to Rs 1,104 crore from Rs 1,732 crore a year ago.

Even though the state-run specialised non-life insurer, Agriculture Insurance Company, has increased its business by 13% in January to Rs 437 crore, it has done very badly in the 10-month period between April and January as its business dipped by 10% to Rs 6,087 crore during the period. In contrast, the private sector players on the space have performed reasonably well during the period under review.

Country's largest private sector non-life insurer ICICI Lombard's business grew by 28% to Rs 1,452 crore in January from Rs 1,137 crore a year ago. Similarly. Bajaj Allianz's business was up by 23% at Rs 1,662 crore from Rs 1,354 crore a year ago. Similar is the condition of almost all the other private sector general insurers.

It is alleged that as a result of MISP (motor insurance service providers) ruling, which caps automobile dealers' commission for to 19.5% for sale of own damage (OD) insurance policies, private sector non-life insurers have started incentivising the car dealers through unfair means so as to keep their business growth intact. Being state-owned firms, the four PSU general insurers and the ones which are working as arms of PSU banks, are losing the car insurance business heavily to their private sector peers as they can't indulge in wrong wayS to make money.

The matter has come to the notice of the sectoral regulator, IRDAI, too which has expressed its concern over the illegal practice. However, no action has been taken by the government on the issue.

The reasons for state-run general insurers acting as laggards are galore. Prominent among them being delay in appointment of top posts in the PSU general insurers. So much so that it took more than four months for the government to appoint a full-fledged CMD for New India Assurance. In a similar fashion, the appointment of regular CMDs at National and United also took considerable period of time for the government. Particularly, in case of the appointment of Girish Radhakrishnan as CMD of United took remarkable time as in his earlier assignment he was posted in London and it took time for getting all the clearances for him to assume his new office in Chennai. In absence of regular appointment of CMD, these PSU general insurers were being run by the directors who were acting as acting CMDs. We know it well as the acting CMD doesn't have major powers to take crucial decisions.

Second prominent reason is the government's backtracking on its promise of providing a sum of Rs 4,000 crore to the three state-owned general insurers (Oriental, United & National) for their recapitalisation. The government had earlier promised that it will be providing the amount for recapitalisation of the three insurers so as to improve their solvency margin, which shows the financial strength of an insurance company.

But, nothing of the sort was announced by the interim finance minister Piyush Goyal while presenting the Union Budget for the next fiscal year on February 1. It has thrown cold water on the three insurers as they are groping in the dark in absence of recapitalisation amount. The head of one of the three general insurance companies told National Herald that what can one do if the government was unable to fulfil its own promise as recapitalisation can take place through the Budget only and next budget will be presented by the new government which is likely to happen by the middle of the current year. The problem was that the government has also initiated the process of merger of the three insurance companies so as to get the merger listed. It has further aggravated the problem of these insurers.

Of late, the global credit rating agency, AM Best has maintained the under review with negative implications status for the financial strength rating of C++ (Marginal) and the long-term issuer credit rating of "b" of National Insurance Company Limited (National).

The under review with negative implications, status has been extended pending the receipt of an expected capital injection by India's government, as communicated by National's management, as well as the review of operating results for the financial year ending March 31, the agency said in a statement. It is not for the first time the agency has downgraded National's rating.

On August 17 last year, the ratings of National were downgraded, following a significant reduction in Nation's capital position. The ratings were placed under review with negative implications pending the progress of initiatives to improve risk-adjusted capitalization. These initiatives are still ongoing, and the company's management expects significant capital injections by India's government. Therefore the under review with negative implications status is extended, it said.

True, the government has launched a host of state-run insurance schemes as part of Pradhan Mantri Jan Dhan Yojana and some of which includes Pradhan Mantri Suraksha Bima Yojana, Pradhan Mantri Fasal Bima Yojana and Ayushman Bharat. However, the benefit of these schemes have been grabbed mostly by the private sector players. In the case of Ayushman Bharat, the companies like New India Assurance was yet to win the bid for a state for their scheme.

When it comes to Pradhan Mantri Fasal Bima Yojana, the state-owned insurers are the new entrants and hence they lack the expertise to run the scheme in an efficient manner, say the experts. Secondly, the government has made it mandatory that the claims under the scheme will have to be settled by the insurer, in case it was not reviewed and approved within the two-month period. As a result, the private sector companies are relying on drones to do the needful, for which the new set of regulations came in force since 1 December.

However, the PSU general insurers are still waiting for the final guidelines to come from the DGCA (director general of civil aviation) before they can even think of using drones. It has further resulted in the piling up of claims and the PSU general insurers are compelled to settle those claims without verifying them as two-month period is too a short period for them to do so. This all shows that the government has turning a Nelson's Eye towards general insurers so as to benefit the private sector insurers.

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**Source**

## *'Change in customer preferences will boost innovation in insurance sector' - The Hindu Business Line – 19th February 2019'*

The change in consumer preferences is likely to drive product innovation in the general insurance industry in India.

According to Tajinder Mukherjee, Chairman and Managing Director, National Insurance Company (NIC), increasing customer expectations has been changing the landscape of general insurance products in India.

"Super flexible insurance solutions such as use-based insurance and telematics-based where we can have options such as pay as you drive or pay how you drive are in the offing. There is also increasing talks on devising products that can be customised based on individual behaviour," said Mukherjee at the Assocham Insurance Leaders Meet 2019 on Regulations, Disruption and Product Dynamics here recently.

The general insurance industry has grown at a CAGR of nearly 13 per cent in the past five to six years, and is currently estimated to be close to Rs 1,50,000 crore. Given the kind of growth of the economy and supported by a rising middle-class population, the industry is likely to touch Rs 4-lakh crore by 2025.

TOP

Source

## *Merger of three general insurers likely in FY20 - The Economic Times – 19th February 2019*

The proposed merger of the three state-owned general insurance firms will happen only in the next fiscal, said two government officials aware of the developments. "We will further bring down the losses before setting up a combined entity," said one of the officials.

The government had announced merger of National Insurance Company, United India Insurance Company and Oriental India Insurance Company in the Budget 2018. The government has now directed these firms to make their operations more efficient and low cost, while the companies are also looking at monetizing their assets including real estate to raise revenues, the official said.

The other official said the government is also looking at issues such as the need for a review of the HR practices across the three firms. "Right now there are no synergies," the official said. "Any merger will further impact the commercial interest of these insurers." The government had plans to list the merged entity. In 2017-18, it had listed National Insurance and General Insurance Company, divesting 11.65% and 12.5% stakes, respectively, in the two companies.

An executive at Oriental India Insurance said that the government is also expected to infuse some capital to help these companies. In quarter ended September last year, the three insurers had posted a combined loss of around Rs 1,800 crore. "The market share of all the public sector general insurance companies has also come down," the Oriental Insurance executive said.

Oriental had posted a loss of Rs 240 crore in the second quarter of this fiscal, against a profit of Rs 200 crore in the quarter ended September 2017. As per latest data from Insurance Regulatory and Development Authority of India (IRDAI), market share of National Insurance Company for gross direct premium till December 2018 fell by 9.52% to 8.63%.

United India Insurance share also came down by around 4.88%. Last year, the government had initiated a six-point reform agenda for general insurers which included sustainable and prudent business, talent management and customer orientation. Financial services secretary Rajiv Kumar in a tweet said, "Aim is to develop comprehensive reform agenda in six themes to modernize public sector GICs. Committed to work towards safety net of all citizens."

TOP

Source

## *With rise in cybercrime, firms take cover – The Hindu – 18th February 2019*

With cybercrime increasing exponentially, firms from varied sectors such as information technology, banking and telecommunications, including start-ups, are queuing to purchase cyber insurance.

Though there are no concrete statistics yet to quantify the number and value of cyber insurance policies taken by firms in Tamil Nadu, there has been an upswing in demand, according to insurance firms. According to insurance broking and risk management firm Marsh, the Indian cyber market has seen a big upswing in the last 18 months. India is the third most heavily cyber-attacked country in the world.

Tata AIG, HDFC Ergo, ICICI Lombard, Bajaj Allianz and New India are the major players in the cyber insurance market.

**Crores in premium**

Data provided by Marsh shows that approximately 325–350 standalone cyber insurance policies have been sold, with a gross underwritten premium of $10 million -$12 million (Rs 65 crore-Rs 80 crore) — roughly 0.4% of global premium.


Anup Dhingra, president — FINPRO & Private Equity M&A, Marsh, said that well-publicised data breach events in the U.S. and the Western world and recently enacted laws such as the European Union's General Data Protection Regulation (GDPR) had been driving the uptake in cyber insurance by Indian firms with global exposure.

The CEO of a firm that caters to the banking sector in Chennai, on condition of anonymity, said they had taken a huge insurance cover.

"We deal with huge information and public data which is crucial and that's why we opted for cyber insurance," he said.

Bajaj Allianz General Insurance, one of the players in the cyber insurance space, has received requests for cyber insurance from large corporates and multi-national companies involved in IT-related services. But of late, the firm has been witnessing an increase in inquiries from small and medium enterprises and start-ups too. Bajaj Allianz General Insurance, which was the first to offer cyber cover for individuals, said this segment was at a nascent stage in India due to low awareness.

Sasikumar Adidamu, chief technical officer, Bajaj Allianz General Insurance, said, "As per the survey results of Allianz Risk Barometer 2019, cyber incidents have been considered the top business risk in India for 2019, with companies increasingly concerned in the wake of mega data breaches, privacy scandals and major IT outages."

He added that factors driving individuals and corporates to purchase cyber insurance were increased connectivity through digital devices, a high cybercrime rate, government emphasis on digitisation, GDPR, increased awareness on and ease of making digital payments and the increasing use of social media across all age groups.

**Solo coverage**

Interestingly, HDFC ERGO General Insurance has a policy which covers individuals from major cyber risks such as unauthorised online transactions made on an individual's bank account/debit or credit card by a third party for purchases over the internet. In addition, it covers the damage caused to an individual's reputation in case a third party publishes any 'harmful' information on the Internet.

Anurag Rastogi, member of executive management, HDFC ERGO General Insurance, said, "There is a rising demand for the insurance product, which has also become the need of the hour to cover individuals against cyber risks and frauds.

That said, over the last three years, we have seen large corporates and banks buying commercial cyber insurance products, and with growing awareness, mid-sized corporates too are seeking to buy a cyber security insurance policy."

***TOP***

**Source**

## HEALTH INSURANCE

### *NABH accreditation for hospitals simplified and digitalized – Mint – 21st February 2019*

In order to extend benefits associated with Insurance Regulatory and Development Authority of India (Irdai) and Ayushman Bharat scheme to small scale hospitals across India, the government has digitalized and simplified the National Accreditation Board for Hospitals and Healthcare Organizations (NABH) accreditation process.

The NABH, a constituent body of Quality Council of India (QCI), handling global accreditation in Indian healthcare sector under ministry of commerce and industry has revamped the entry-level certification process to make it simpler, digital, faster and user-friendly.

The revised process is driven through a new portal called HOPE - Healthcare Organizations' Platform for entry-level-certification with a focus to promote quality at nascent stages by enrolling a wide range of hospitals across the country including healthcare organizations (HCOs) and small healthcare organizations (SHCOs).

"The aim is to create a momentum for HCOs and SHCOs that want to avail benefits associated with Irdai and Ayushman Bharat by getting themselves NABH certified along with the primary aim of creating a quality healthcare ecosystem in India," a statement issued by ministry of commerce and industry said on Thursday.

"The idea of cashless payment to patients under insurance coverage has been promoted by Irdai to reduce financial burden on households. The Irdai has mandated hospitals to ensure a quality healthcare ecosystem through NABH Entry-Level Certification Process," the statement said.

Billed as the world's largest health assurance scheme, Ayushman Bharart, aims to provide free health insurance of Rs 5 lakh per family to nearly 40% of the population—more than 100 million poor and vulnerable families based on socio economic caste census (SECC).

"Universal and affordable health services in Ayushman Bharat are possible through hospitals that have quality health care facilities. More and more hospitals now want to be a part of the scheme. Also, NABH accredited hospital have more benefits over non accredited hospitals," said Indu Bhushan, CEO Ayushman Bharat (Pradhan Mantri Jan Arogya Yojana), ministry of health and family welfare.

HOPE is not just confined to certification of HCOs/SHCOs but also enables them to comply with quality protocols, improve patient safety and the overall healthcare facility of the organization. The online platform provides smooth and secure registration and a self-explanatory questionnaire to be filled by the HCO/SHCOs.

A mobile application has also been developed to support HCO/SHCOs for directly uploading geo-tagged and time stamped evidences required for compliance to the standards.

"It has also changed the assessment process which is now carried out on a technology based application where the data is captured and validated on a real-time basis," the statement said.

NABH has been working to ensure reliability, efficiency and global accreditation in Indian healthcare sector using contemporary methodologies and tools, standards of patient safety and infection control. NABH accreditation provides assurance of quality and care in hospitals at par with international benchmarks.

NABH has designed an exhaustive healthcare standards for hospitals and healthcare providers that have been accredited by International Society for Quality in Healthcare (ISQUA) the apex international accreditation body.

In order to support maximum HCO/SHCOs in the country, QCI and NABH have partnered with several organizations like, Indian Medical Association (IMA), Patient Safety and Access Initiative of India Foundation (PSAIIF), Consortium of Accredited Healthcare Organizations (CAHO) and other stakeholders for spreading awareness about the process, the ministry statement said.

TOP

Source

## *Health insurance may cover expenses incurred on Ayurveda, Unani treatment - The Economic Times – 21st February 2019*

The insurance regulator has issued draft norms for standard health insurance products with basic sum assured of Rs 50,000 to Rs 10 lakh defining the benefit structure for individual insurance buyers with no upper age limit. While the minimum entry age is kept at 18 years for principal insured, the maximum age at entry is 65 along with lifelong renewability. There shall be no maximum exit age.

The basic standard policy will also cover expenses incurred on treatment under Ayurveda, Unani, Sidha and Homeopathy systems of medicines subject to fixed and standard sub-limits based on the sum insured. The standard product will be offered on indemnity basis, as a standalone product and it cannot be combined with critical illness covers or benefit based covers.

In a draft circular IRDAI said that products differ significantly with each other in terms of benefits offered. "It is considered essential that the potential customers seeking health insurance shall have an access to the basic health insurance covers so as to enable them to choose the coverage based on the need," the regulator said.

The standard health product will cover hospitalisation expenses including room, nursing expenses, Intensive Care Unit, Intensive Cardiac Care Unit expenses, dental treatment, necessitated due to an injury, plastic surgery, necessitated due to disease or injury and domiciliary hospitalisation. However, 5% of copay or the insured pays, is part of the product feature.

TOP

Source

## *West Bengal told to return Rs 193 crore received under Ayushman Bharat - The Economic Times (Delhi edition) – 21st February 2019*

The Centre has asked the West Bengal government to return the Rs 193 crore it had received for the central government's Ayushman Bharat health insurance scheme, along with any interest earned, since the state has pulled out of it.

This follows the Mamata Banerjee-led state government's failure to respond to a January 11 letter in which the Centre had urged it to reconsider its stand of pulling out of the scheme and requested for a meeting. The state, which has its own health insurance scheme for the poor—'Swasthya Saathi' scheme—was running Ayushman Bharat under a joint banner—Ayushman Bharat-Swasthya Saathi—but later withdrew from it to continue with its own.

"As we have not got any response in this regard, it is opined that the state government of West Bengal has decided not to reconsider its decision of withdrawal and discontinuance of AB – PM JAY," chief executive

officer of National Health Authority, Indu Bhushan, wrote in a letter to the additional chief secretary of West Bengal on February 11. ET has accessed this letter.

The Centre also pointed to the grant-in-aid, to the tune of Rs 193.34 crore, released to the state government towards 50% of the first tranche of the central government scheme. "You are requested to please arrange for refund of grant-inaid amount available with you along with any interest earned by you, if any, after adjustment of claim amount payable/paid for treatment of AB – PM JAY beneficiary families to National Health Authority's escrow bank account," Bhushan's letter said.

Earlier, ET had reported that the Centre had asked the state to reconsider its stand.

TOP

Source

## *Government urged to revoke new Aarogyasri policy for thalassaemia patients – The Times of India – 21st February 2019*


Parents of thalassaemia-affected children on Wednesday urged the state government to revoke the new Aarogyasri policy under which the medical insurance claim amount for treatment of such patients was reduced to Rs 4,260.

Under the new Aarogyasri scheme guidelines issued in February 2018, the financial support for chelation therapy for thalassaemia patients was reduced to Rs 4,260. The scheme was started in July 2014 with a grant of Rs 15,000 for blood transfusion and other treatments for thalassaemia.

Addressing the media on Wednesday, the parents called for revoking the new guidelines as the amount reduces the scope of treatment due to financial constraints.

Aleem Baig, joint secretary of Thalassemia and Sickle Cell Society, said that a patient needs to undergo several medical check-ups and take expensive medicines for blood transfusion and undergo blood transfusion. Due to the new guidelines, they have been unable to buy medicines for the patients.

"In some cases, patients living in districts are required to travel for treatment. The new policy increases the financial burden on the patients, hence, it must be revoked and replaced with the previous policy which allowed for a relatively better compensation", said Baig.

One of the parents, Mohammed Ameen said that a child requires nearly Rs 20,000 to Rs 25,000 monthly expenses for treatment, medical check-ups, cardio scans and MRIs and that the pump used for treatment costs around Rs 25,000 to Rs 30,000.

Clinical psychologist Dr. Azra Fatima, who is also a thalassemia patient, said that when the scheme was introduced, it had given hope to patients and parents of thalassaemia-affected patients. "The recent revision of the policy grants has made things difficult. A patient incurs a minimum expense of Rs 10,000 to 12,000 a month which is difficult to be met by anyone," she said.

There are nearly 2,500 patients suffering from thalassaemia in Telangana, of which 50 per cent are from poor families. Most of the amount received through Aarogyasri scheme by these patients is spent on medicines, and very little is left to undergo blood transfusion and other necessary procedures.

TOP

Source

## *Insuring India against health shocks – Hindustan Times – 21st February 2019*

It has been just over a year since the Pradhan Mantri Jan Arogya Yojana (PMJAY) health insurance scheme was announced in the 2018 Union budget. Formally launched in September, PMJAY has the potential to be a milestone on the road to achieving universal health coverage in India.The need is real: out-of-pocket expenditure due to health crises is a leading cause of indebtedness in the country; health shocks push over 4% of Indian households into poverty each year.

Moreover, private health insurance is unaffordable for most Indians, and the persistent scarcity of formal sector jobs means that employment-based health coverage is a luxury available only to a privileged few. These realities are inconsistent with the aspirations of a middle-income, middle-class society.

PMJAY aims to provide the poorest 40% of the population (about 100 million families) with health insurance covering over 1,300 secondary and tertiary care packages at public and empanelled private hospitals, up to an annual limit of Rs 500,000. It promises to be a bigger and better version of the previous government-sponsored health insurance schemes in India, including its predecessor, Rashtriya Swasthya Bima Yojana (RSBY; launched in 2008) and over 20 state schemes. At their best, health insurance schemes can expand access to private hospitals using public money, empower government hospitals to improve the quality of their services, and protect the poor and vulnerable from the costs of hospitalization. At their worst, the transactional nature of insurance and the complex web of stakeholders can overwhelm state oversight capacity, resulting in beneficiaries only in name, widespread fraud, and minimal impact on health and financial protection. India has experienced both.

There is a long list of issues related to developing a strong health system raised by PMJAY, but our focus is specifically on the potential (and limits) of PMJAY to protect families from the financial risks posed by health crises.

While the intent to target the poorest 40% is laudable, it should be recognised that a far larger share of the population is in need of a safety net to protect against health-induced financial shocks. Although India halved the share of the population in extreme poverty from 45% in 1994 to 22% in 2012, it has moved from being mostly poor to mostly vulnerable, with a majority hovering close to the poverty line. In fact, according to the National Sample Survey of 2012 (the most recent available), the difference in monthly per capita expenditure of a poor household at the 40th percentile of the population and a richer household at the 80th percentile is only about Rs 1,000. This is a small gap if one considers that the average cost of private hospitalisation is about Rs 24,000, implying that significantly higher population coverage will ultimately be required to ensure financial protection for all. Of course, covering more people would cost more money. This would be more affordable if PMJAY had offered a more modest benefit package with fewer high-cost tertiary care services. The tradeoff between covering more people and offering more services is one that all countries face.

An added advantage of expanding population coverage is that it would open the door to better methods for identifying eligible households than PMJAY's present approach. The current route relies on the Socio-Economic Census (SEC) database. However, operationalising and updating the 2011 SEC data to target beneficiaries effectively is a complex and challenging task. It is especially tough in densely-populated urban environments, as many migrants may not be captured by the SEC, and jobs and addresses frequently change. Future options include extending eligibility to all ration cardholders, adopting exclusion instead of inclusion criteria (such as eligibility for all except formal sector workers), or going universal.

For now, PMJAY cannot be expected to be the primary vehicle for reducing the overall reliance of families on out-of-pocket payments (OOP) to tackle their health crises. This is because total OOP as per the government's health accounts data, is at least 20 times higher than the PMJAY budget, and it is mostly

spent on drugs and outpatient care, which are not covered by the scheme. Indeed, at the current juncture, leaving both of these out of the benefit package makes sense. They do not impose the same one-time financial shock on a household as a hospitalisation episode. Empanelling outpatient providers and drug sellers would also be prohibitively complex, with huge scope for fraud and over-use. And since a large share of drug spending is essentially due to families self-treating themselves as they lack access to adequate medical care, any solution must focus on improving the quality of care on offer. This is easier said than done, but other reform initiatives under the umbrella of Ayushman Bharat (the overarching mission under which the PMJAY falls) — including the establishment of 150,000 health and wellness centres — could make an important contribution to this agenda.

In the long run, governments will have to spend far more on health than they have in the past if protection against health shocks is to be assured. Globally, there is a clear relationship — the more countries spend on health via the public purse, the lower the reliance on impoverishing and inequitable out-of-pocket spending by households. In India, the government estimates that 62% of health expenditures are incurred directly by families out-of-pocket. This is among the top 10 in the world. The main reason is not insufficient revenue, but because India allocates well under 5% of government spending to health, far less than the lower middle-income country average. Sharp increases in the health budget cannot be achieved overnight, but the first step is to start building a health system – not just a scheme – that is able to spend additional resources effectively.

At the same time, PMJAY beneficiaries must be empowered. Awareness campaigns to inform beneficiaries of their entitlements, including how and where to access services, will be essential to ensure they get the care they need on a cashless basis. Further, robust grievance redressal mechanisms to help resolve patient complaints will also be important.

While states are rightly in the driver's seat for PMJAY implementation, there are areas where the centre should take the lead. Among the most important is to ensure portability of coverage across state lines, a key commitment of the scheme. This offers huge potential, especially to migrant populations and those residing in states with fewer hospitals offering high-quality care. But achieving portability should not be left to the states. There is a need for a centrally managed modality for beneficiary validation, pre-authorisation, and claims management for cross-border patients.

Achieving these goals would go a long way towards establishing health insurance as a core pillar of India's social protection system.

***TOP***

**Source**

## *How to choose between Disease-Specific and Critical Illness insurance plans - Financial Express – 21st February 2019*

It's never easy to pick the right health insurance plan especially with insurance companies offering a plethora of options to choose from, making the task all the more daunting. Adding to this are regular reports that highlight the fact that many diseases that were often encountered usually post 50 years of age have now begun to strike as early as in one's 40s – just because of the stressful and unhealthy lifestyle that most follow.

Even GOQii – a popular fitness technology platform – in its past reports has stated that in India, three people out of 10 above the age of 30 suffer from a lifestyle disease that eventually escalates to critical health issues. The data submitted by World Life Expectancy suggests that there are over 30 million heart patients in India alone, while stroke, cancer, lung diseases and heart ailments continue to remain the key causes of deaths.

No doubt, innovative advancements in medical sciences have increased the chances of survival; it becomes equally important for one to be financially prepared to avail the offered facilities. No wonder, it's imperative to prepare oneself for an exigency and the best option available is to buy an adequate insurance cover in place. Considering the given scenario, Disease-Specific (DS) and Critical Illness (CI) insurance plans seem to be some of the best available options.

Here is everything that you must know about each of these insurance plans that may help you to choose the right one for you and your family.

**Disease-Specific Plan**

As the name itself suggests, a disease-specific plan provides cover for the cost of entire treatment of a specific disease at all stages including diagnosis stage to advanced treatment. The key highlight of a disease-specific plan is that unlike a critical illness plan, it waives future premium of the insured under certain circumstances. Also, disease-specific plans are comparatively cheaper than critical illness covers as they are precisely designed for individuals looking for a low-cost insurance to cover a specific disease they may feel they are most prone to. People with a family history of a particular critical disease must buy a disease-specific plan along with a regular health insurance plan.

**# What is covered?**

A disease-specific plan provides coverage for a specific disease including cancer, diabetes, kidney ailments, cardiac ailments, hypertension, stroke and most recently even dengue at all stages — early or advanced. Such a plan helps in saving significantly on premium and also takes care of the financial burden in case of a life-threatening situation. The insured is paid a lump sum amount or the medical expenses are indemnified.

**# How much to be insured?**

If you need disease-specific insurance, it is important to know for what disease you wish to get insured. Although generally, a Rs 10-lakh sum assured is sufficient for most diseases, you may still go for a higher amount just to be mentally and financially secure. As with investing, educating yourself is essential to making the right choice.

**# The waiting period**

The waiting period in case of the disease-specific products is completely waived.

Here is a competitive analysis of the yearly premium for a disease specific cover of Rs 10 lakh for a 30-year-old non-smoker male residing in a metropolitan city.

| Insurer | Disease Specific Plan | Cover Up to | Premium (Rs.) |
|---|---|---|---|
| Future Generali Total Insurance Solutions | Cancer Protect-Option 1 | 80 years | 1178 |
| HDFC Life Insurance | Cancer Care- Silver | 75 years | 826 |
| Max Life Insurance | Cancer Insurance Plan | 75 years | 2738 |
| Aegon Life Insurance | iCancer | 70 years | 3056 |
| ICICI Prudential Life Insurance | Cancer Protect | 75 years | 1361 |

**Source:* www.policybazaar.com

**Critical Illness Plan**

Critical illness insurance plan is another financial plan specially designed to cover some specific critical illnesses including cancer, stroke, heart attack, organ transplant, severe burns and many more. Under the CI plan, the insurer pays a lump sum amount – equal to the sum insured – to the insured on acquiring any of the serious ailments mentioned above. The entire lump sum benefit can be used for the payment of the cost of care and treatment, recuperation expenses and even pay off any debt if any taken during the treatment.

**# What is covered?**
The number of critical illnesses covered by the insurers may vary. However, most insurers generally cover 8 to 20 major critical illnesses, including cancer, stroke, heart attack, organ transplant, kidney failure, aorta surgery, heart valve replacement, paralysis, loss of limbs, and loss of speech. The coverage amount is generally anywhere from Rs 1 lakh upwards.

**# How much to be insured?**
It is quite known that the entire cost of critical ailments typically crosses several lakhs. Industry experts suggest that one must always look at buying the policy depending on a few important factors like family history, type of job, medical inflation and age. In general, it is suggested to take a cover of or above Rs 10 lakh considering the current healthcare costs.

**# The waiting period**
Generally, the policyholder needs to survive for 30 days after the diagnosis of the critical illness to make a claim. However, some companies even provide policies with zero or 28 days surviving period. Talking about the waiting period, it is mostly the first 90 days after the policy is issued. Claims made within 90 days are not covered under the policy.

Here is a competitive analysis of the yearly premium for a CI cover of Rs 10 lakh for a 30-year-old non-smoker male residing in a metropolitan city.

| Insurer | Plan | Premium (Rs.) |
|---|---|---|
| Apollo Munich Health Insurance | Optima Vital | 3834 |
| Max Bupa Health Assurance | Critical Illness | 2631 |
| HDFC Ergo | Critical Illness Plan | 2949 |
| Reliance General Insurance | Reliance Critical Illness | 3229 |

**Source:* www.policybazaar.com

TOP

Source

## *Ahmedabad: Health cover raised under MA schemes - The Economic Times – 20th February 2019*


In a move that will help the poor and the middle class, the Gujarat government on Tuesday raised health insurance cover provided under the state's Mukhyamantri Amrutum (MA) and Mukhyamantri Amrutum Valsalya schemes, to Rs 5 lakh from Rs 3 lakh. The increase is in line with the Centre's Ayushmaan Bharat scheme.

The increase in health cover will benefit 68 lakh families in the state. In addition, the income limit for benefits under the MA Vatsalya scheme has also been raised to Rs 4 lakh from Rs 3 lakh, which will increase the number of beneficiary families by 15 lakh, the government announced in the interim budget it presented in the state assembly.

In another boost to the state's health sector, the government announced that the monthly remuneration of 3,753 ASHA facilitators will be raised by Rs 2,000. "They will be provided saris as uniforms like ASHA workers," deputy chief minister Nitin Patel said while presenting the vote-on-account.

TOP

Source

## *ESIC board okays super speciality treatment for workers with just 6-month contributions to ESI - The Economic Times – 20th February 2019*

The Employees' State Insurance Corporation (ESIC) Tuesday relaxed the norm of minimum two years' contribution towards its health insurance scheme to six months for its insured persons to avail of super speciality treatment, which will give a major relief to those suffering from chronic diseases, said sources.

Besides, the ESIC, in its board meeting here chaired by Labour Minister Santosh Gangwar, also increased the maximum individual income of dependents from the current Rs 5,000 per month to Rs 9,000 per month for getting benefits under the Employees' State Insurance (ESI) scheme.

"The ESIC board today (Tuesday) decided to reduce the minimum contribution period for getting super speciality treatment under the ESI scheme to six month from the existing two years in its meeting," a source said. The source further said: "The board has also increased the maximum individual monthly income of dependents like son, daughter, mother and father of the insured person (IP) under the ESI to Rs 9,000 per month from existing Rs 5,000 per month."

The board also decided that the ESIC would pay the entire expense of the hospitals run by the states, which are tied up by the body for treatment of its insured persons under the ESI scheme. Currently, the ESIC pays the seven-eighths of the expenses, while the respective states bear one-eighth of the expenditure of these hospitals.

The unions also suggested that if the service in these hospitals do not improve future despite bearing entire expenditure by the ESIC, those should be taken over by the body to run itself. The proposal to rope in multiple contractors to improve housekeeping and security services in a hospital run by the ESIC, was deferred for next meeting. Currently, one contractor each for housekeeping and security services are engaged.

During the meeting, it was also reported to the board that the mandatory contributions towards the ESI scheme by employers and employees' have been reduced to 4 per cent and one per cent from the existing 4.5 per cent and 1.5 per cent of wages, respectively. The decision to reduce the contributions by employers and employees towards ESI was taken in the last board meeting of the ESIC.

The ESIC protects employees against the impact of incidences of sickness, maternity, disablement and death due to employment injury and to provide medical care to insured persons and their families. The ESI scheme applies to factories and other establishments such as road transport, hotels, restaurants, cinemas, newspaper, shops, educational or medical institutions wherein 10 or more persons are employed.

***TOP***

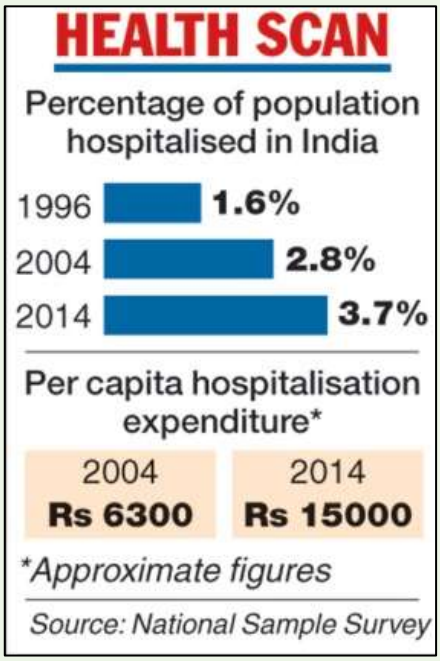
**Source**

## *PM's hospitalisation-cover plan could eat up healthcare funds – The Telegraph – 19th February 2019*

The bill for the Narendra Modi government's flagship programme that provides up to Rs 5 lakh hospitalisation cover yearly to poor households could balloon to unforeseen levels and threaten other health services, economists have told government officials in closed-door presentations.

The presentations, outlining the findings of an exercise to estimate costs of the Pradhan Mantri Jan Arogya Yojana, have suggested that the scheme with current funding levels can provide hospitalisation to only 30 per cent of its target beneficiaries.

India's Finance Commission, a body tasked with guiding financial relations between the Centre and states, had last year asked researchers at the Institute of Economic Growth (IEG), New Delhi, to assess costs of the scheme launched by Modi in September 2018.




The scheme pledges cashless hospitalisation to treat over 1,350 illnesses or health disorders to about 100 million poor households — or 500 million people, an estimated 40 per cent of the country's population. Since its launch, it has paid for the hospitalisation of over 1.2 million patients. But the IEG exercise indicates that at current funding levels, the scheme cannot support the hospitalisation needs of more than 30 million households, according to people familiar with the presentations who do not necessarily agree with all its findings.

The Union health ministry has estimated the scheme requires an investment of Rs 1,100 per household per year. But the presentations suggest that to provide hospitalisation to all who need it across 100 million households, this number would surge to Rs 2,400 crore or more.

The Union health ministry has for 2019-20 earmarked Rs 6,400 crore — or 10 per cent of Rs 61,398 crore of its annual health budget. But to support hospitalisation needs of all 10 crore households, the bill could precipitously rise to levels where it will consume much more than half of the Centre's health budget.

Health economists fear that such a rise could also strain states' resources and prompt some states to draw funds away from other health programmes. Three factors — an increase in hospitalisation rates per unit population, an increase in per capita expenditure on hospital services in an unregulated healthcare environment, and a rise in hospitalisation needs for non-communicable diseases — are expected to drive the rise in the scheme's bill.

National sample survey statistics show that hospitalisation rates in India have increased from 1.6 per cent in 1996 to 2.8 per cent in 2004 and further to 3.7 per cent in 2014. Per capita hospital expenditure rose from Rs 6,300 to Rs 15,000, and hospitalisation for non-communicable diseases rose from 38 per cent in 1996 to 62 per cent in 2014.

Health economists point out that hospitalisation rates in countries with robust health coverage are higher – 13 per cent in the UK and 15 per cent in China. Even within India, some states have higher hospitalisation rates than the national average – 13 per cent in Kerala and 7 per cent in Tamil Nadu. Finance Commission officials and IEG researchers declined to comment on the details of the presentation before a final report is submitted to the commission. But the findings appear consistent with concerns long articulated by sections of health economists.

"The PMJAY scheme itself will make more and more people seek hospitalisation," said Sanjay Mohanty, a health researcher at the International Institute of Population Sciences, Mumbai, who was not associated with the costing exercise. "Government investment will have to increase over time."A senior health official pointed out that the IEG numbers are based on assumptions.

The official said "available evidence" suggests the scheme's hospitalisation expenditure is about Rs 15 crore a day. Even at Rs 20 crore a day, the annual cost would be Rs 7,300 crore and an allocation of about Rs 10,000 crore and Rs 12,000 crore would be sufficient for additional operating costs, the official said. However, the official conceded that if hospitalisation rates across India approach those of Kerala, the scheme's cost would go "sky high."

TOP

Source

## *Why there is no cap on insurer's profit in Chhattisgarh - The Hindu Business Line – 19th February 2019*

To avoid windfall gains for insurance companies, a model tender document, under Ayushman Bharat, specifies the maximum gain an insurer can make if there is a surplus after claims settlement. But Chhattisgarh has not included the pertinent clause while implementing the scheme in the State.

This implies that if there is a surplus after settling all claims (say, of Rs. 100 of the premium, total claims during policy period is Rs. 60), then the entire profit ( Rs. 40 in this case) can be kept by the insurer. In Chhattisgarh, which has adopted the hybrid model, Religare Health is the insurance partner.

**Non-inclusion of clause**

According to the 'Model Tender Document for Selection of Insurance Company', clause 12.2 deals with the refund of premium by the insurer (in case claims are less than the premium), and additional premium by the State Health Agency (SHA) (in case claims are more than the premium).

In case of surplus, if claims ratio (ratio of claims incurred to net earned premium) is less than 60 per cent, then the insurer can keep only 12 per cent of premium as profit when it comes to category A States (10 per cent for category B States).

If claims ratio is between 60-70 per cent, then the maximum profit an insurer can keep is 15 per cent (12 per cent in category B States), and if claims ratio is 70-80 per cent, then the insurer can keep 20 per cent profit (15 per cent in category B States, where the claims ratio is 70-85 per cent).

In the same clause, the burden of excess claims – to be borne by insurer and State – is also mentioned. If the claim settlement ratio exceeds 120 per cent in case of category A States and 115 per cent in case of category B States, then the excess amount over and above this threshold will be shared equally between the insurance company and the government (between Centre and State in the premium sharing ratio). But this is provided the Centre's premium and excess claim burden does not exceed the maximum ceiling set for the particular State.

Chhattisgarh has not included this clause, implying the insurer gets to keep the entire profit in a good year (when claims ratio is less than 100 per cent) and will have to bear the excess claims burden in a bad year (when claims ratio is more than 100 per cent). "We have not included the 12.2 clause as our experience so far has been that the loss ratio is over 100 per cent. In such a case, the insurer bears the burden of excess claims entirely. If we had adopted the clause, then the State's outgo would be higher if claims are in excess of 115 per cent," explains Vijendra Katre, Additional CEO of Ayushman in the State.

**Profit no cap**

In case of profit, too, the insurer gets to keep the entire amount. "If we had included the clause of capping the profit, then the premium could have been higher than the current Rs. 1,100," he adds.

In Chhattisgarh, the State already had Rashtriya Swasthya Bima Yojna (RSBY) launched in 2009-10 for those below poverty line (BPL), with a cover of Rs. 50,000. Aside from this, the State also has a Mukhyamantri Swasthaya Bima Yojana (MSBY), which covers all those who are not covered under RSBY. RSBY has been subsumed under Ayushman, while MSBY continues for other beneficiaries.

Chhattisgarh has adopted the hybrid model to implement Ayushman, where a claim package of up to Rs. 50,000 is taken under the insurance model, while a package of more than Rs. 50,000 is processed under the trust model.

The insurance player on board to implement the scheme in the State is Religare Health, which has quoted Rs. 1,100 per household as premium. There are so far 55.8 lakh smart-card holders, which works out to a total premium of Rs. 600 crore. So far, there have been 2.4 lakh claims, totalling Rs. 168 crore. Katre, however, expects the claims ratio to be in the 95-100 per cent range by the end of the policy period.

TOP

Source

## *Why you should insure yourself against cancer – Mint – 18th February 2019*

Given India's large size, we have earned the moniker of being the world capital of most diseases ranging from diabetes, hypertension to cardiac illness. Which of these causes the most havoc? Two stand out from the dozens of insurance health claim reports that I see each week: infections and cancer.

Mosquitoes and viruses are having a field day because every hospitalisation report is filled with infection claims. But these tend to be low cost requiring just a day or two of hospitalisation. Cancer claims, though fewer, are very large in value. We don't need statistics to prove this. I can count 10 instances of cancer among close family and friends over the past few years. The highest incidence is of breast cancer.

A recent study by Edelweiss Tokio Life suggests that advanced treatment of cancer costs between Rs 10 lakh and Rs 14 lakh on average. A different study by EY suggests that in 75% of homes in India, the treatment cost of cancer is more than the annual income. Distress financing or borrowing to pay is highest for cancer. Cancer is also the most frequent reason for the entire sum assured in a health policy being used up. This is why we must insure for cancer.

Insurers have developed several products to cover cancer costs. The quality of these insurance plans is uniformly good. There are three broad product types: regular mediclaim, critical illness and standalone cancer plans.

A regular mediclaim insurance will cover actual cancer-related costs ranging from expensive diagnostics using PET scans, MRIs or other equipment; treatment including chemotherapy and radiation; and post-treatment care. Exclusions vary but items such as oral chemotherapy, hormonal treatment, cyberknife treatment and certain skin cancers are sometimes excluded. These exclusions will reduce as the regulator is in the process of setting conditions for what must be covered in health insurance. The advantage of mediclaim insurance is that it covers all illnesses and not just cancer. However, from the perspective of covering cancer, the issue is that the sum assured is often insufficient because the plans are bought with the intention of covering lower value hospitalisation claims. Also, you must be healthy when you buy mediclaim. As you grow older or develop chronic ailments, the insurance policies become more expensive to buy.

Critical illness insurance was first sold about 15 years ago as an add-on to life insurance. However, health insurers have taken up the concept and introduced several standalone critical illness plans. These plans do not reimburse actual costs but pay a fixed amount if you are diagnosed with cancer, or other listed critical illnesses. These plans also require you to undergo a health test and be relatively fit when buying.

Most recently, some insurers have introduced standalone cancer plans. Like critical illness insurance plans, these pay a fixed amount when you are diagnosed with cancer but they can have four advantages. They can be issued without a medical test, the benefit can be paid for earlier stage cancer compared to critical illness or standard mediclaim plans, you can have a pre-existing condition unrelated to cancer and still buy this, and these are economical. Some of these insurance plans waive of future premium requirements if you are diagnosed with early stage cancer.

Which of these insurance plans should you buy? Your first preference should be to get the regular mediclaim with a high sum assured of Rs 20 lakh or more. This should then be supplemented with a critical illness cover or a standalone cancer plan. The choice will depend upon your health and how much you can pay. At age 50, a critical illness plan for a sum assured of Rs 20 lakh will cost about Rs 25,000-30,000 per year whereas a cancer standalone insurance will cost between Rs 3,000-5,000.

The battle against cancer is daunting. A Ken report suggests that the probability of developing cancer is 16.6%. A Novartis-CII report on breast cancer highlights that about half of breast cancer patients are diagnosed when they are less than 50 years old. Of those that are diagnosed, over 70% are in advanced stage 3 and 4, where mortality is the highest. Insurance can do little to reduce cancer incidence or improve detection. Your priority, then, must be to get yourself screened periodically for cancer.

TOP

Source

## *Ayushman Bharat: How world's largest healthcare scheme fared in first 150 days - Financial Express – 18th February 2019*

Over 12 lakh people have been treated in less than 150 days since the launch of Ayushman Bharat scheme. In addition, more than 1.7 crore beneficiary e-cards have been generated providing access to healthcare under the world's largest healthcare scheme, according to Pradhan Mantri Jan Arogya Yojana (PM-JAY) dashboard. At present 14,856 hospitals have been empaneled under the scheme. The scheme was launched by Prime Minister Narendra Modi on September 23 last year in Ranchi.

The scheme aims to provide health protection to 10.74 crore poor, deprived rural families and identified occupational categories of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data (nearly 50 crore beneficiaries). It offers a benefit cover of Rs. 500,000 per family annually.

Meanwhile, Finance Minister Piyush Goyal earlier this month said the government may provide more funds for the healthcare scheme in 2020. "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 had 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 had said.

TOP

Source

## *Health Insurance: 5 things to look at while choosing the right policy - Financial Express – 16th February 2019*

Rising healthcare costs have made it essential to include a health insurance policy in the financial portfolio. The expenses otherwise could result in depletion of savings to a large extent. Health insurance can cover both you and your family from high inflation in the healthcare sector. However, there are many policies with different features available in the market. A few elements you might want to factor in to choose the right health insurance policy for you are mentioned below:

**Check the claim settlement ratio**

As the name suggests, 'Claim settlement ratio' refers to the ratio of the claims paid out, to the total number of claims requested in a particular policy year. This can always give you an idea of what your chances are of getting a claim settled during a medical emergency. Nobody wants a rude surprise at a time of crisis. Look for insurers that have a claim settlement ratio of 90% at least.

**The extent of the cover you need**

It's important to ascertain the size of the health insurance cover you need basis the city you reside in, the ailments you may be prone to and your family history. Also factor in inflation when you do the math.


With age, your need for healthcare and chances of getting hospitalized increase and the insurance premium increases simultaneously. In fact, after a certain age you may need to undergo medical tests to avail a substantial insurance cover. Opt for an adequate cover in the first instance so you don't need to raise the cover frequently.

**Individual Vs family floater**

Family floater policies cover the entire family with a single limit that can be utilised by anyone in the family. A family floater covers your spouse, parents and dependent children under the age of 25 years.

You need to make your pick basis your needs. For example, if your parents are senior citizens, keep them under a separate insurance because of the age and the risk element involved. On the other hand, if you get a separate cover for each one in the family, it may cost you more than what a floater would cost.

**Pre-existing ailments and the waiting period involved**

All health insurance companies cover pre-existing illnesses but there's a wait time involved which varies from 36 months to 48 months, depending on the company's terms and condition. So, look out for a policy that allows a shorter waiting period on pre-existing ailments. Another thing to keep in mind here is the need to make an accurate disclosure of your pre-existing ailments at the time of purchase of health insurance. Any inaccurate information can lead to rejection of claims.

**Compare the plans carefully**

Before you make your pick, look at a range of products and compare in terms of the features mentioned above. Once you are down to 2 to 3 probable health policies, compare in terms of the inclusions and exclusions associated. Some other features that you can consider include maximum renewal age, sub-limits on expenses, hospitals in a network, add-ons and riders such as critical illness and accidental rider, no claim bonus benefit, etc. Do not base your choices on low premium but fewer terms and conditions associated with a plan.

***TOP***

**Source**

## *Watch Your Health eyes tie-ups with more insurers for wellness solutions - The Hindu Business Line – 15th February 2019*

An insurtech start-up is working with insurance companies to provide wellness solutions to their health-insurance policyholders to help improve their fitness levels and lower claims and annual premiums.

Watch Your Health has already tied up with five insurance companies, including Aditya Birla Capital Life Insurance, Edelweiss Tokio Life, Cigna Health Insurance, ICICI Lombard General Insurance, Reliance General Insurance, as well as two TPA service providers, Health India Insurance TPA Services and Bharti Assist Global.

"We want to sign up with more partners and are in talks with a few more companies," said Ratheesh Nair, founder and CEO, Watch Your Health, adding that it aims to function like a credit bureau that will give health scores and help people port their insurance policies easily.

"There is no health score and every time customers have to get a medical check up done to buy any insurance policy," he noted, adding that the company wants to eventually tie up with all insurers providing health cover.

While most health insurance covers offer such solutions, it is up to the customer to take it up, according to Nair. "We follow up with customers on an individual basis," he said. Founded in 2015, the company has a team of health coaches, including doctors, dieticians, physiotherapists and psychologists, to service 25 lakh customers.

It has also tied up with companies such as Bharat Petroleum, Talwarkars, Suburban Diagnostics and RBL Bank, to provide health and wellness solutions under their employee wellness programmes.

***TOP***

**Source**

## CROP INSURANCE

### *Insurance firms reap rich gains from crop scheme – The tribune – 20th February 2019*

The crop insurance scheme of the government is proving to be a profitable venture for insurance companies in Himachal Pradesh.

As per the information collected under the RTI, insurance companies collected a premium of Rs 78.12 crores in Himachal Pradesh for the year 2017-18. Out of this amount, 2 per cent was paid by the farmers and the rest contributed by the union and state governments. For commercial crops the farmers have to pay 5 per cent of the premium. However, in the current financial year, the insurance companies have settled claims of farmers for paltry Rs 3.12 crores till date.

The information under the RTI has revealed that it was estimated that the farmers claims worked out to be Rs 36.31 crores. Out of this, the claims of Rs 28.31 crores were approved by various authorities. However, the companies have settled claims of just 3.12 crores so far. With the financial year closing in March next month it seems that the private insurance companies are likely to make windfall profit from the small state like Himachal.

Information gathered under the RTI has also revealed that in the year 2016-17 private insurance companies had made handsome profits out of the crop insurance scheme in the state. The insurance companies collected a premium of Rs 71.51 crores during the period but paid claims of Rs 44.66 crores to the farmers.

Information under the RTI has also revealed that in the year 3,82,470 farmers were covered under the insurance scheme. Out of these the claims were paid to just 23,573 farmers. In the financial year 2016-17 as many as 3,79, 925 farmers were covered under the scheme out of which 1,12,601 were given claims.

Dinesh Chada, an RTI activist who has gathered the information, while talking to The Tribune, said that it was clear from the data that the private companies were making huge profits at the cost of farmers. Minister for Agriculture Ram Lal Markanda, when contacted, said that he would look into the matter. If any claims of the farmers are pending the government would ensure that these are disbursed.

The farmers of Himachal have been suffering due to climate change. Due to inclement weather agriculture experts have advised the farmers to change cropping patterns. In such a scenario where companies are not paying insurance claims of farmers the issue is likely to gain prominence in the forthcoming parliamentary polls.

**Healthy profit**

Insurance companies collected a premium of Rs 78.12 crores for the financial year 2017-18. However, in the current financial year, the insurance companies have settled claims of farmers of the state for just Rs 3.12 crores till date.

In year 2016-17, the insurance companies collected a premium of Rs 71.51 crores but paid claims of Rs 44.66 crores to the farmers.

***TOP***

**Source**

## *Flawed yield data cost Parbhani farmers crop cover - The Hindu Business Line – 20th February 2019*

Deficiencies in crop cutting experiments (CCEs), which forms the basis of compensating insured farmers, are costing farmers in Parbhani district of Maharshtra's Marathwada region dear.

As per the crop insurance scheme — Pradhan Mantri Fasal Bima Yojana (PMFBY) — guidelines, State governments have to plan and conduct certain number of CCEs to assess crop yield and in turn the insurance claim payable to farmers. But this write found during a visit to Parbhani that not only were the requisite number of CCEs not done for the kharif 2017 season, wide lapses in the process has left farmers in the lurch.

**What CCE entails**

District/subdivision-level officials from the Revenue or Agriculture Departments conduct the CCE — that is, harvest the crop, thresh, winnow and weigh the output to estimate the yield. As per the guidelines, a minimum of four CCEs at the village level, 10 at the revenue circle, 16 at the taluk and 24 at the district level need to be done. Under 'Preconditions for Implementation of the Scheme', the guideline mandates use of smartphones and satellite technology for conducting the CCE. It also says that there should be an audit of the CCE with necessary checks and balances. Further, digitising the CCE process, including geo-coding (providing the latitude and longitude of the CCE location), date/time stamping with photographs (of the CCE plot and CCE activity), is a must.

But a scrutiny of the records accessible to the writer, suggests that in Parbhani the mandated number of CCEs were not conducted in some instances, monitoring of the process was slack, and there were serious gaps in the manner in which CCE details were recorded.

After a farmer activist from the region — Vishwambar Gorve — filed an RTI, the District Collector's office set up a committee to investigate the CCEs carried out during the kharif 2017 season. The committee had a farmer representative.

A copy of the committee's report, which is with *BusinessLine,* shows that most CCE forms did not have the signature of the farmer in whose field the CCE was done. Nor was there any photograph with geo-tagging of the farm; and most of the experiments were performed manually. A total of 146 CCEs were done through the CCE app in kharif 2017. The committee indicated that in some cases the yield data were overwritten and altered. In the original CCE report of Parbhani and Jinthur taluks, which the writer inspected, in most documents, the date column was blank. Secondly, in the space where the signature of the officials who were present when the CCE was done is required, there was only the sign of the gram

sevak – the person from the Village Panchayat Office. Also missing were the signatures of the Village Sarpanch and Police Patil (officer-in-charge of the police station in whose jurisdiction the village falls) which are mandatory.

Farmers at Parbhani also complained that with Reliance General (the insurer that covered crops in kharif 2017) objecting to some of the CCEs done in Sonpeth taluk, the data of Pathri taluk was used as the basis to settle claims. At Pathri, no official came to the field to do the CCE, claim farmers.

**Guideline on yield estimate**

As per the government guideline, where the required number of CCEs could not be conducted in an insurance unit, the yield estimate can be generated by (i) clubbing with neighbouring units (village in this case) or (ii) adopting yield estimate of next higher unit, or (iii) adopting the yield of neighbouring insurance unit with maximum correlation.

However, in the case of Sonpeth, it cannot be compared to Pathri. As Pathri had a less favourable weather condition than Sonpeth in kharif 2017, farmers wonder how the reported CCE data shows higher yield in Pathri than in Sonpeth.

The problems at Parbhani highlight the severe lapses in the implementation of the crop insurance scheme at the ground level. Unless there is auditing and strict watch over the activities of implementing agencies, deficiencies in PMFBY will continue.

***TOP***

**Source**

## *Swiss Re banks on tech to improve claim-settlement in crop insurance - The Hindu Business Line – 19th February 2019*

Global reinsurer Swiss Re is working on using technology to improve claim settlement in crop insurance scheme.

**Satellite imaging**

"One example of the new technology we have brought into the country is in the agriculture sector. Satellite imaging is quite powerful these days," said Amitabha Ray, Head of CM P&C, India, Swiss Re, India Branch.

It can be used very quickly to estimate the drought level or soil moisture content level in the area, he added. Based on the image, in case the area is drought-stricken, farmers can get payments faster. Similarly, the technology can also predict if the soil moisture content is low, which would then mean that going forward the crop output is going to be low.

"You can estimate the deviation that will happen and can settle claims," said Ray, adding that the use of technology such as this can be a means of value addition to the current methods under the scheme. In an interaction with *BusinessLine*, he said the reinsurer also carried out a pilot project recently with the Mahrashtra government.

"We are a big agriculture insurer worldwide. We are trying very hard on making the claim settlement process much faster and smoother with the use of technology. We are also trying to use technology to understand crop losses better," he said. In India, it services close to 8-10 per cent of the crop insurance market. Swiss Re, which is the world's second-largest insurer, set up a branch office in India in 2017.

Satish Raju, CEO, India Branch, Swiss Re, said the company is keen to work across all line of businesses in the country. "We want to utilise our international experience. We are keen to help support the country's focus in terms of health, crop and help improve insurance penetration. This is our broad-based approach," he said.

***TOP***

**Source**

## *Insurance firms reap Rs 15,000-cr profit, fail to pay farmers Rs 2,800 cr – The Tribune – 18th February 2019*

Companies empanelled under the Pradhan Mantri Fasal Bima Yojana made a quick profit of over Rs 15,000 crore in two years, but failed to pay claims worth over Rs 2,800 crore to farmers in the same period.

As per information obtained under the RTI from the Agricultural and Farmers' Welfare Department, the crop loss incurred by 3.01 crore farmers during the fiscal 2016-17 was an estimated Rs 16,448 crore. But the companies approved a payment of Rs 16,242 crore and finally ended up paying Rs 15,902 crore — Rs 546 crore less than the estimated loss.

Similarly, in the financial year 2017-18, the crop loss by over 1.25 crore farmers was estimated at Rs 17,992 crore, of which the companies approved claims worth Rs 16,611 crore but paid only Rs 15,710 crore till November last — Rs 2,300 crore less than the estimated loss.

Ropar-based RTI activist Dinesh Chadha claimed the figures clearly showed the scheme was "of the insurance companies, by the companies and for the companies".

He pointed out that the companies, despite the big profits, had failed to establish dispute settlement forums at the district level. "Maharashtra is one example. Farmers don't know whom to approach for compensation."

The yojana was launched in 2016 to supposedly help the farmers. In all, 18 companies were awarded contracts under the scheme — five in the public sector and 13 in the private sector. The companies earned a profit of Rs 15,795 crore in all, of which the share of private companies was Rs 8,147 crore.

***TOP***

**Source**

## *When cover for farmers came a cropper - The Hindu Business Line – 17th February 2019*

Farmers of Jalna district in Aurangabad Division of Maharashra, who planted pomegranate, mango and sweet lime in the 2017 kharif season and lost their crop because of a drought are in a state of despair.

Despite coughing up premiums for the Pradhan Mantri Fasal Bima Yojana (PMFBY), they have not received a penny from the insurance company, which contends that the relevant papers have not reached it. However, the SBI branch through which the farmers tendered the premium refutes the contention of the insurance company.

Caught in this game of 'passing the buck', farmers are fast losing hope of getting their compensation in the near future.

The distress of the 140-odd farmers is understandable as there is hardly any redress mechanism available to them. In a bid to understand the core issue better, this writer reached out to the farmers, the SBI branch in Badnapur and the representative of the insurance company, IFFCO Tokio.

**Farmers' angst**

The excessive reliance on the fickle weather conditions has left farmers high and dry in this arid Marathwada region. The story of Raisingh Zendusingh Sundrde from Rajawadi Village in Badnapur, Jalna, perhaps best explains this. Awarded as the best *mosambi farmer* in the area in 2016, Sundrde soon ran out of luck and suffered huge crop losses in 2017.

Despite taking cover under the PMFBY, he is now caught in a debt trap. For the 20 acres split between him and his brothers, he paid a premium of about Rs 32,000 through the SBI branch in Badnapur in 2017.

"I actually borrowed from a money-lender at 4 per cent monthly interest to pay the premium and am now neck-deep in trouble," laments Sundrde.

The insurance for that particular season was handled by IFFCO Tokio for the region. Ramdas Shesharao Bhargaje, a farmer who has two hectares and had insured his mango crop, is also in the same boat.

"I paid the premium for my crop to IFFCO Tokio through SBI, but didn't get any payment. Farmers who paid through other banks or through the CSC (Common Service Centre) have been paid the claim."

The amount of premium paid by the 140 farmers of the area totals Rs 9.76 lakh. All of them have paid through the SBI branch. "I get suicidal instincts sometimes…if I go to the bank to enquire, the manager doesn't speak properly; he doesn't give respect…" says Sundrde.

**What the SBI branch says**

The farmers in the area had joined together and had lodged a complaint with SBI and also the District Collector, but no action has been taken.

When *BusinessLine* visited the SBI branch in Badnapur, the manager didn't offer much help. "We don't know! We sent all documents and premium as and when we received them. We don't know anything else about this…"

Curiously, the manager had no information of the insurer or any representative who could clarify on the matter.

*BusinessLine* tracked the representative of the insurance company concerned and reached out to him on phone. "We didn't get the documents of the farmers on time, so we didn't process their claims," was his reply.

**No solution in the near term**

With no office set up by the private insurer — IFFCO Tokio — in the district, farmers running from pillar to post — from bank branches to government agencies — have little hope of the issue getting resolved.

Though the missing documents have now finally reached the insurer, it doesn't look like the farmers will receive their settlement. "Only now the bank has sent the documents. But we can't settle the claims now as we haven't received government subsidy for these farmers," states the same IFFCO Tokio representative.

According to the guidelines for the PMFBY, if there has been incorrect/partial/non-uploading of details on the national crop insurance portal due to which insurance has been denied, the banks concerned will be held responsible for the payment of claims. But in this case, SBI has washed its hands off the issue.

After over a year of struggle, the farmers are despondent. It is shocking that policies taken over a year back are still pending settlement for want of documents.

Government norms mandate that crop insurance payments are settled within 45 days. But, then, there is no redress system in place to ensure that the timeline is met and action is taken against the banks or insurers.

***TOP***

Source

## MOTOR INSURANCE

***Getting a motor insurance? Here are riders you should know about - Financial Express – 22nd February 2019***

Motor insurance policies are classified into two types: basic/ third-party car insurance policy and comprehensive policy. A third-party insurance policy solely covers damages to others in case the policy holder meets with a car accident. Comprehensive policies provide more protection to the policy holder as well as others involved in the accident.

Motor insurance policies can be distinguished on the idea of features such as liability coverage, collision coverage, medical payment coverage and personal injury coverage. Insured value, also known as insured declared value (IDV), is the total value insured which a customer can claim. An individual must select a car insurance policy that is appropriate as per one's needs.

The insured value is the total sum that the insurer is liable to pay in case of eligible claims. For example, a car insurance policy may offer low premium but, at the same time, a low insured value. You should do a firm assessment of your automobile insurance. Look at various riders that are there in a motor insurance.

**Add-on covers**

Many insurance companies these days provide special facilities called add on covers. The most commonly recommended add-on is zero depreciation, which enables you to claim the full cost of replacing car parts damaged in accidents without having to pay from your pocket.

Next comes engine protect which is considered particularly relevant for owners of brand new high-end cars and is normally available for cars that are up to three years of age. Essentially, engine protect or machinery breakdown cover compensates for even those engine-related repairs that are not related to accidents.

It is useful and worth purchasing because the cost of repairs in case of damage to engine can be very high. Buying a return to invoice cover will ensure that in case of total loss or theft of your car, you will get the original invoice value, including registration charges and road tax paid, of the car and not just the insured declared value (IDV).

Deductible is the portion of damages payable by the car insurance policy holder. A higher deductible means the insurer will pay the remainder amount of damages in case of an accident. This also leads to a lower premium.

**No claim bonus**

No claim bonus (NCB) is the benefit that a car insurance policy holder gets, generally in the form of discount in the annual premium payable, for not filing any claims during a year. Before buying a automobile insurance policy, one must learn about the NCB in order to be able to make the best decision should the need for a claim arise in a year. For example, a damage that would cost less than the no claim bonus can be paid by the insurance policy holder out of his or her own pocket, therefore making most of this feature.

Many insurers provide car insurance policies through on-line as well as offline modes. Before buying or renewing an automobile insurance policy on-line, one must look at these aspects.

***TOP***

**Source**

## *Stop, not just low premium! Take buying car insurance policy seriously; 4 critical factors – Financial Express – 18th February 2019*

There is no denying the fact that in India, most car owners buy car insurance as a mere formality, without giving it a required thought. Moreover, a major reason why people buy car insurance is that as per the Indian law, you need to have adequate insurance for your vehicle before you drive the vehicle on the road. While zeroing in on car insurance, low insurance premium often remains the sole deciding factor. This certainly results, most of the time, in not having an adequate coverage for your car against any damage caused during an accident.

Truth better be told; buying car insurance must always be given as much importance as buying the car itself. However, before buying car insurance, it is very important to get introduced to its various components. But, with a little knowledge and understanding of car insurance, you can best optimize your insurance purchase and enjoy great benefits in the future. As a car owner, it is very important for you to be aware of all the facets of car insurance before finalizing a product.

**Third Party Insurance is Mandatory**

As per the Indian Road Safety Act and Indian Motor Vehicles Act, third party insurance is compulsory for every vehicle. As per the new law, third party insurance cover for all new cars is mandatorily for a period of three years. So, people buying a car for the first time must make sure at least to buy a third party insurance for your car before driving the vehicle on the roads. Third party insurance offers the vehicle an adequate coverage against damages caused to any third party that may include a person, vehicle or property.

However, under third party insurance, you cannot seek any claim for any damage caused to own vehicle. Hence, it is always suggested to buy a comprehensive policy for your car, especially a brand new car, which covers the damages caused to third party as well as your own vehicle. This is important since the cost of getting your car repaired is increasing every day and a policy which covers your car does make sense.

**Look for Comprehensive Cover for Complete Protection**

It is strongly advised to go for a comprehensive insurance cover for your car as it offers protection against all damages caused to the car and self in the event of an accident. In addition to accidental damages, comprehensive car insurance protects your car against any theft, accidental fire, and any other damage caused to the car. Apart from buying a comprehensive insurance, you must also understand and spend on buying a few add-ons on your policy in order to get optimum protection. Some popular add-ons to look for are zero-depreciation cover, engine protection and road-side assistance.

The premium of the car is also dependent on the total cubic capacity of the car's engine and the geographical location where the car is registered. The insurance premiums for a same model of a particular manufacturing year may differ if registered in a metropolitan region as compared semi-urban or rural area, generally the latter being cheaper.

**Know Your Car's Insured Declared Value**

As a car owner, you must know that the insurance premium of your car is directly linked to the Insured Declared Value (IDV) of your car. The greater the IDV, the higher will be the premium of the car. Simply put, IDV is the maximum amount that you get under a motor insurance policy in case of theft or total damage of the car.

**Prefer Buying Insurance Online**

Third party insurance as well as a comprehensive motor policy are generally provided by the car dealer, but often the premium cost is added into the vehicle purchase price and it may not be the best available option. So, it is always advisable to check for the best available quotes for your car on your own as most of the times the prices for comprehensive motor policies are inflated.

Also, you must check whether or not a 'voluntary deductible' is added by your dealer in your policy. This is purely done in order to lower your car insurance premium. However, under the deductibles clause, you agree to share the costs of repair with your insurer during a claim which means you need to shell out additional money from your own pocket.

As a thumb rule, it is always recommended to check quotes online. By buying car insurance online, you get the option of comparing policies of multiple insurers with detailed description of what all is included and it helps in making an empowered decision.

TOP

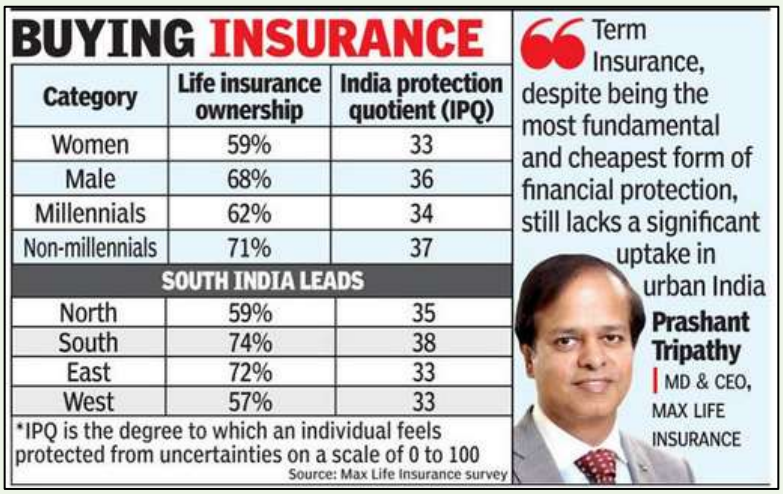
Source

## SURVEY & REPORTS

### *Women grossly under-insured: Survey – The Times of India – 21st February 2019*

Women are grossly under-insured in India with only 33% saving for future stability, according to a new Max Life Insurance survey of 4,500 respondents in 16 cities. Women apparently spend a lot more of their salary for the household — with 42% of earnings diverted to basic expenses, as against working males who spend only 28%. The survey showed that women are more focused on saving for their children's education than in saving for their old age or untimely death.

Life insurance ownership was lower at 59% for women, compared to 68% for men, said the survey. A large number of Indians fear that future medical expenditure might wipe out all their family's savings. As high as 50% of urban Indians fear their life will be severely impacted with the death of the breadwinner.




And more than a third (36%) of urban Indians feel their savings would last less than a year in case of critical illness or death.

More than one fifth of the population also felt they would have none to support them in case of disability, critical ailments or death.

But millennials (25-35 years) as a group showed up the worst when it came to financial awareness as most of them prioritised spends on gadgets, luxury and travel over protection.

Only 44% of youth were aware of the word "term insurance" and just 17% own it. But millennials with kids are more aware and have a higher ownership (22%) of insurance.

South Indians are more aware of the need for insurance. Among the metros, however, Delhi, Lucknow, Patna and Bhubaneswar owned the most insurance (64-66%), compared to cities like Ludhiana, Patna and Kolkata which owned only 15-36% insurance.

Indians are seen to be severely underestimating how much they would have to spend if a family member had a heart attack or cancer. The report showed only 10% term buyers are invested in any critical illness rider, and more than 80% are unaware of treatment costs for heart disease and cancer.

When it came to the mode of purchase of insurance, only 6% of those surveyed bought policies online. About 15% buy from their bank, and an overwhelming 79% still buy from their local insurance agent.

TOP

Source

## *Only one of five urban Indians has term insurance: Study - The Economic Times – 21st February 2019*

Close to 65% of urban Indians have purchased a life insurance policy, but only one out of five people has bought term insurance so the level of protection is very low. A study conducted by Max Life Insurance and market research firm Kantar IMRB says that the overall India Potection Quotient (IPQ) stands at 35, which is quite low.

The IPQ is the degree to which an individual feels protected from uncertainties on a scale of 0 to 100. The proprietary tool developed by Max Life Insurance with Kantar IMRB is based on among other things the awareness and ownership of life insurance, level of preparedness for future uncertainties and the degree of preference for pure protection plans.

**How India scores on protection**

| City | India Protection Quotient (score out of 100) |
|---|---|
| Delhi | 46 |
| Hyderabad | 44 |
| Ahmedabad | 44 |
| Chennai | 42 |
| Vishakhapatnam | 41 |
| Lucknow | 40 |
| Mumbai | 39 |
| Bhubaneswar | 36 |
| Patna | 35 |
| Jaipur | 33 |
| Bangalore | 28 |
| Kolkata | 28 |
| Pune | 27 |
| Bhopal | 25 |
| Ludhiana | 21 |
| ALL INDIA | 35 |

*Source: India Protection Quotient 2019 by Max Life*

The study looked at 4,566 respondents aged 25-55 years in 15 top cities in India. “It reveals some startling findings about the state of protection in the country and the attitudes and apprehensions people have about life insurance,” said Prashant Tripathy, Managing Director and CEO of Max Life Insurance.

Term insurance, despite being the most fundamental and cheapest form of financial protection, still lacks a significant uptake in urban India, Tripathy said while releasing the survey.

So, there is an urgent need for Indians to understand the true value of protecting one's family from the uncertainties of life, he added. "We hope the results of this study, act as a wake-up call for consumers and the industry at large and help increase financial protection in the country," he said.

Delhi scored highest on the protection quotient, followed by Hyderabad and Ahmedabad. Surprisingly, metros such as Pune and Bangalore, which have a very high percentage of millennials and highly educated professionals, were among the lowest scorers.

“This indicates that being tech savvy or having access to information alone does not help. One needs to have the right attitude to buy protection,” said Tripathy.

The study found that millennials in the age group of 25-35 years like to spend on travel and luxury but very few think about protecting their families against financial hardships in case of early death. Only 44% of them were aware of term insurance and just 17% had bought it. An alarming 22% of urban Indian youth do not even consider buying a life insurance policy because they have other investments.

This tends to change when millennials become parents. Millennials with kids save more for their children's education and marriage and the primary motivation to buy term insurance is to secure a financial amount for these aspirations in future. When compared to the rest of the demographics, millennials with kids have an overall greater term insurance awareness and subsequent ownership of 22% as against a general level of 21%.

TOP

Source

## INTERVIEW

### *'We want to avoid windfall gains for insurance cos' - The Hindu Business Line – 17th February 2019*

As the country's cashless health insurance scheme — Pradhan Mantri Jan Arogya Yojana (PM-JAY), popularly referred to as Ayushman Bharat — completes 150 days, PM-JAY CEO Indu Bhushan spoke to *Businessline* on the scheme's performance and the challenges ahead. Excerpts:

**What are your reflections on the journey, and what challenges lie ahead?**

The scheme has had a good start, as close to 12 lakh patients have benefitted. We have issued 1.55 crore cards. A large number of people access it to look at eligibility and every five to six seconds someone is provided benefit of the transaction management system.

Now, the focus is on reaching the last mile. Of the bottom 40 per cent target group, the bottom-most 5-10 per cent people are more disadvantaged and within families women and children may not be getting the benefit. We need to start working on mainstreaming standard treatment protocols, medical audits, work with hospitals to ensure that quality services are being given.

There are three models in place — trust, insurance, hybrid — for the scheme. In the insurance model, for example, giving Rs 1,500 crore to an insurance agency could be problematic for the fear that insurance companies are the ones that benefit out of the scheme...
We are not giving away money, but money is being used to pay the hospital. We have capped the maximum claim ratio at 85 per cent. Beyond that the insurance companies have to give the money back to the government. None of the insurance companies will make a windfall gain.

For example, government pays Rs 100 in premium and the total claim during policy period by hospitals is Rs 60, potentially insurance company is making a profit of Rs 40, but they can't keep that Rs 40. They have to return Rs 25 to the government and maximum they can keep is Rs 15. We want to avoid windfall gains for insurance companies. It does not work like that in private insurance. Also, insurance companies are not assured of their 15 per cent profit as claim ratio can over run 100 per cent of premium paid, and insurance companies can lose money.

**In Budget you have not got the amount you demanded. You will get it at later stage is the impression. Will this affect the uptake?**

We will give the States all the money that they need. We have already released large amount of money, but I cannot share the numbers and we have told them that whatever is due from our side, we will pay. There is no crunch. Bihar, for example, was given more than sufficient resources and we have asked the money back from them as they are not being able to spend it.

**Kerala and West Bengal are disgruntled that even as the scheme is co-branded along with existing State schemes it is not publicised in the letter issued by the Prime Minister. How do you handle politics over branding?**
Co-branding has been agreed upon with all States through MoUs, which is clear that we will have Ayushman Bharat and their own scheme together. The PM's letter, however, only talks about the scheme (central). We have not customised the letter for the State, except for the language, may be we could have done so.

**You are keeping the private sector at bay because of your costs. Can you explain the methodology for determining package rates, as currently different States are using different package rates?**
Different kind of hospitals have different rates. From government-run to missionary and private hospitals, it varies. Hospitals in metros will have a different costing structure as compared to outside metros. It is a complicated exercise and we need a lot of data. We are working with the Department of Health Research by establishing 24 different expert committees to work on costing. DHR has done a lot of work on determining costs for 200 packages and it is in progress.

**If you look at it from a micro perspective, the scheme is great, but on a macro level there are debates, issues and criticisms...**
There was this man from Jamshedpur living with a three kg tumour near his ear for 23 years. He did not have the money to get treated. He got to know about the scheme and the tumour was removed. This scheme is helpful as even in public hospitals things are not free, you still have to pay or some services are not directly available, and the scheme mechanism covers everything.

***TOP***

**Source**

## *'Only 35% of farmers are covered under crop insurance' - The Hindu Business Line – 15th February 2019*

Changing rainfall patterns, droughts, flooding and geographical redistribution of pests and diseases have posed a major challenge before Indian agriculture. With the impact of climate change looming large on agricultural productivity, the insurance sector has a big role to play. However, the implementation of crop insurance scheme is mired in squabbles while the insurance sector has not penetrated deep into the Indian market. G. Srinivasan, Director, National Insurance Academy (NIA), Pune, shared his views on these issues. Excerpts:

**Climate variability and extremes are having an impact on agricultural production systems. How do you analyse the suitability of crop insurance schemes?**
Indian agriculture is extremely vulnerable to climate changes and is largely dependent on the monsoon. Drought, unseasonal rains, cyclone, floods, hailstorms and climate extremes have brought huge losses to the farmers. Crop insurance is clearly a reasonable solution to the losses arising out of these events. The Pradhan Mantri Fasal Bima Yojana provides monetary compensation to losses arising out of climate risks and also due to pests and diseases.

**What steps are needed to ensure comprehensive coverage of crop insurance schemes?**
The aim is to provide coverage to all farmers. However, this is a tall task. The scheme is mandatory for loanee farmers, while it is voluntary for others. The premium is largely borne by the Government and the farmers pay only a small component of the premium. Only about 35 per cent of farmers are covered now and the intention of the Government is to increase it to 50 per cent by 2020.

**What changes do you think must be introduced in the Pradhan Mantri Fasal Bima Yojana (PMFBY) and the Restructured Weather Based Crop Insurance Scheme (RWBCIS) to make them more farmer-friendly?**

The revised operational guidelines have made the scheme more farmer-friendly. The key is use of technology in a big way to eliminate the difficulties encountered now due to manual procedures. What is important is to ensure that farmers get compensation quickly. The impediments to faster claim payment can be easily addressed with active collaboration of insurers and Government authorities.

**What is your take on India-specific Natural Catastrophe (NatCat) solutions in the wake of climate change?**

India is highly exposed to natural catastrophes. The repeated occurrence of cyclones, floods, earthquakes is a grim reminder to the vulnerabilities of the people. The insurance sector should design a simple natural catastrophe product with affordable premium and simple claim payment methodology. The Government can pay the premium for people below the poverty line. The funds lying with disaster agencies can be utilised for buying insurance cover rather than using them after an event. Parametric covers can ensure claim payments happen immediately.

The number of complaints regarding unfair business is substantial. During the last three years, the Insurance Regulatory and Development Authority of India (IRDAI) has received 2,16,772 complaints. Your comments.

The complaints on unfair selling can be tackled by creating insurance awareness among the public and also insurance marketing personnel. Agents and insurance intermediaries need to be well trained and asked to explain insurance products fully to the customers before concluding the sale. More transparency and standard practices among insurance players could also help in solving this problem to a large extent.

***TOP***

**Source**

## INSURANCE CASES

### *Firm booked for insurance data leak – The Times of India – 20th February 2019*


Nearly two years after a Greater Noida-based engineer was allegedly cheated of nearly Rs 3 lakh by telecallers who identified themselves as agents of a private insurance firm, police have booked the company for cheating and under sections of the IT Act.

Police said the FIR was registered in the case after investigations — in one of the fake call centre scam cases — revealed that some of the insurance company officials used to illegally sell customers' data outside. Company officials will soon be called for questioning, they said.

According to the victim, Pradeep Kumar (34), a resident of La Residential housing society in Noida Extension, the alleged callers had duped him of Rs 2.85 lakh in the name of policy upgradation.

"I received the first call in June 2017 when the caller introduced herself as a company agent and to support her claim, she told me that she had all my policy and personal details. Then she assigned a male consultant handling my account, and on his advice I transferred Rs 2.85 lakh in eight transactions in various accounts — Policy Solutions, Costumer Solutions etc," he said.

"Later when the calls stopped coming, I went to the bank where executives told me that the callers were fake and so were the accounts in which I transferred my money. Since then, I have been running from

police stations to SSP office to get my FIR registered, but nothing really happened till February 15 when finally the current SSP directed Bisrakh police to book the company for cheating," Pradeep added. "Taking the matter of data leak and ever-rising cases of fraud with people into cognizance and on the basis of the complaint of the victim, we have booked the company under Sections 420 (cheating) of IPC and Section 66 of the Information Technology Act and due action will be taken," said Anil Kumar Shai, SHO of Bisrakh police station.

"Company officials will soon be called for questioning in the case," said another official.

TOP

Source

## *Accident caused by 14-year-old boy: Pay compensation first, Karnataka HC to insurance company – The Times of India – 19th February 2019*

In a case wherein the accident was caused by a 14-year old minor boy, the high court has directed the insurance company to settle the compensation awarded by a Motor Accident Claims Tribunal (MACT) in the first place. Putting an end to 13-year old litigation, the court has directed the New India Assurance Company Limited to deposit Rs 1 lakh with 6 per cent interest in four weeks time.

Turning down the argument put forward by the insurance company that they can't be saddled with the burden of paying compensation in this case, Justice N K Sudhindrarao however observed that the company can recover the amount from the owner of the offending car involved in the accident.

57- year old Thimmaji had died on way to hospital following a road accident which occurred at about 6.15 am on February 21,2005 when a Maruti Esteem car driven in a rash and negligent manner by one Jabeeulla, a 14-year old boy hit her in Gujari lane of Davanagere. The Davanagere traffic police then filed charge sheet against Jabeeulla before the Juvenile Justice Board, Shivamogga, Since he was a juvenile offender, he was acquitted on November 7, 2008. Thimmaji's children then moved MACT, Davanagege seeking for Rs 10 lakh as compensation claiming that she was hale and hearty and was earning Rs 6,000 per month.

However, by an order passed on April 16, 2009, the Motor Accident Claims Tribunal (MACT), Davanagere directed the insurance company as well as the owner of the car to jointly pay Rs 1 lakh compensation with interest at 6 per cent. The insurance company then moved the high court against this award claiming that Jabeeulla, a minor was not authorized to drive the car and the insurance policy doesn't cover such exigencies. It was further argued that Shivakumar, the owner of the car and Nagaraj, a licensed driver whom the owner had entrusted the car were negligent and should be held responsible for allowing the minor boy Jabeeulla to drive the car.

TOP

Source

## *Insurer pulled up for suspecting grieving widow's late claim – The Times of India - 19th February 2019*

A consumer court has ordered an insurance company to clear the claim of a woman grieving her husband's untimely death. The woman's claim was being delayed on grounds that she had approached the firm too late. The court has now given United India Insurance 45 days to make the payment and, additionally, compensate the woman for causing her agony.


July 31, 2016 was a dark day for Parvati of Siddapura in July 31, 2016 was a dark day for Parvati of Siddapura in Uttara Kannada district. Her husband Babu Manja Poojari was killed in a road accident on Sirsi-Kumta Road after his motorcycle collided with a speeding jeep. A case of accidental death was registered with Sirsi town police and investigation progressed.

Twenty months later, Parvati realised her husband was a United India insurance policy holder, with a personal accident cover of Rs 1 lakh. The widow collected all the papers and submitted the claim documents on March 18, 2018. Parvati furnished more documents, including police reports on Poojari's death. But the insurer treated her with suspicion, quizzing her over the 20-month-long delay in raising the claim.

Realising the authorities were not planning to provide her the rightful claim, the widow approached the Uttara Kannada district consumer disputes redressal forum, Karwar, a day before her husband's second death anniversary.

While Parvati presented her claim to the consumer forum, authorities of United Insurance Co. Ltd's Sirsi branch appeared through their counsel and stated that the woman had not provided adequate documents towards her husband's accident insurance money and an explanation has been sought regarding the 20-month delay in applying for same.

The judges examined the case for seven months and pulled up United India Insurance for unfair delay in paying the sum to Parvati, despite her explaining to them in a letter that she was in shock after her husband's death and wasn't aware of the intimation procedures towards the policy.

The judges added that it was clear that Parvati had no mala fide intention as her husband's sudden death has been recorded by police and she had submitted the documents to the insurer. Citing a Supreme Court ruling against repudiating claim on account of delayed intimation, the judges, on February 8, ordered that United India Insurance pay Parvati her husband's insurance sum of Rs 1 lakh with interest and an additional Rs 4,000 for the mental agony the widow was subjected to.

**'Despite delay, wife eligible for money'**

According to a city-based insurance expert, there is no specific time period to apply for an insurance claim. "In case of death, the claim has to be made as early as possible. If there is a delay, the reason for the same should be stated convincingly by the claimant. Insurance authorities will examine the case thoroughly before deciding to clear the money. In this case, FIR and death certificates clearly record the accidental demise of the man and the wife is eligible for the money, despite a delay in claiming it," he said.

***TOP***

**Source**

## PENSION

### *Should you hike VPF contribution? - The Economic Times (Delhi edition) – 22nd February 2019*

The Employees' Provident Fund Organisation (EPFO) board has recommended an increase in interest rate of the Employees' Provident Fund (EPF) from 8.55% to 8.65%.

Though this needs to be approved by the Finance Ministry before it becomes binding, savers are hopeful that the proposal will go through especially because we are heading towards a general election and the chances of the ministry rejecting it are remote.

As expected, employee unions are rejoicing over the proposal. "We are very happy about this rate increase because it will directly benefit all EPFO members," says Virjesh Upadhyay, general secretary BMS, and also an EPFO board member. The total subscriber base of EPFO is estimated to be around 6 crore.

**Returns Comparison**

**Comparable debt options with 80C benefit**

| Option | Taxability of interest | Interest Rate (in %) |
|---|---|---|
| Public Provident Fund (PPF) | Tax free | 8 |
| EPF / VPF | Tax free | 8.65 |
| Bank FDs (average rate) | Taxable | 7.5 |
| 5 Yr NSC - VIII Issue | Taxable | 8 |

*The interest rate is for FY19*

*Source: ETIG Database*

In addition to their normal contribution, employees can benefit from this higher interest rate by voluntarily contributing more – i.e. through Voluntary Provident Fund (VPF). Since VPF generate same interest as EPF, it has become even more compelling now. More importantly, the rates offered on EPF are about 1% higher than other options.

"Since this risk-free and tax-free investment option is generating better returns, VPF is a great retirement planning tool and therefore, it should be there in the debt portfolio of all salaried employees," says Mrin Agarwal, founder director, Finsafe India.

VPF is also available for deduction under section 80C and therefore, can be a good tax planning tool. While there is a limit of Rs 1.5 lakh per annum for investment in Public Provident Fund (PPF), there is no such restriction in VPF.

Flexibility and convenience are other advantages of VPF. "Since VPF happens through salary deductions, investors find it convenient. Most companies allow employees to start, stop, increase or decrease their VPF contributions twice a year," says Agarwal.

However, one should not ignore the fact that VPF comes with withdrawal restrictions and full withdrawal possible only at the time of retirement. Savers also should not ignore their goals and asset allocations while increasing their VPF contributions.

Young people are supposed to have higher equity component and low debt component, so VPF may not be a great option for them (ie their debt portion may get full through EPF itself).

"VPF is a very good option for people with higher age and who want to increase their debt portion by reducing equity portion. They can do this by increasing their VPF contribution and reducing fresh equity investment by same amount", says Melvin Joseph, founder, Finvin Financial Planners.

***TOP***

**Source**

## *What a higher EPF interest rate means for you – Mint – 22nd February 2019*

The Employees' Provident Fund Organisation (EPFO) has approved an increase in interest rate on employees' provident fund (EPF) from 8.55% in 2017-18 to 8.65% for 2018-19.

Accordingly, an EPF balance of Rs 10 lakh, which would have earned Rs 85,500 in the previous fiscal, will earn Rs 86,500 in the current fiscal. A higher rate not only puts more money in your account in the short term, over a long period it can also compound to make a significant difference. Besides, the EPF interest is tax-free.

The employer and employee contribute 12% each of the basic salary and dearness allowance to the pension fund every month. Out of the employer's contribution, 8.33% (up to a wage ceiling of Rs 15,000) is credited to the Employees' Pension Scheme, which does not earn any interest.

The higher rate brings cheer on two counts. First, this means more money in your account and, second, EPFO's decision to put 15% of the incremental corpus in equities through exchange-traded fund (ETFs) is yet to be implemented from a subscriber's standpoint.

"Although EPFO is investing 15% of the incremental corpus in equities, methodology for this has not been implemented. This means that the hike in interest rate is applicable on the full corpus, including on the amount invested in equity," said Amit Gopal, India business leader-investments of investment advisory Mercer.

When the rules on the equity part of the fund are implemented, subscribers will have two accounts. One part of the corpus will earn the annual interest rate, while the balance ETF units will earn returns as per the performance of the ETF portfolio companies.

Exempted pension fund trusts will also have to match the EPF interest rate. But experts say that the small hike in the EPF interest rate will not impact these trusts significantly.

TOP

Source

## *PF deposits: EPFO may retain 8.55% rate for provident funds – Financial Express – 21st February 2019*

Retirement fund body EPFO is likely to announce an interest rate of 8.55 per cent on PF deposits for 2018-19, same as provided in 2017-18, to its 6 crore subscribers, a highly placed source said. "The proposal to declare interest rate for this fiscal is on the agenda of the Employees' Provident Fund Organisation (EPFO) trustees meeting on February 21, 2019," a source said.

The source further said, "The interest rate is likely to be retained at 8.55 per cent for this fiscal as provided in 2017-18 as Lok Sabha elections are around the corner. However, the EPFO's income estimates for 2018-19 has not been circulated among the trustees and will be tabled in the meeting."

Earlier the sources had not dismissed completely speculations that interest rate on EPF deposits for this fiscal can be more than 8.55 per cent in view of impending general elections. The Central Board of Trustees (CBT) 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.

The EPFO trustees can also announced the appointment of new fund managers. The trustee would also review the performance of investments made by the body in stock markets.

The EPFO had started investing in the ETFs (exchange traded funds) in August 2016. Presently it invests 15 per cent of its Rs 1.5 crore investible deposits at hand every year in ETFs. It has invested around Rs 50,000 crore in ETFs so far.

TOP

Source

## *PFRDA hopes to reach 2.72 crore subscribers under APY, NPS by Mar-end: Hemant Contractor – The Economic Times – 18th February 2019*

Pension fund regulator PFRDA has reached a subscriber base of 2.65 crore in its flagship National Pension System (NPS) and Atal Pension Yojana (APY) schemes and hopes to cover nearly 2.72 crore subscribers by the end of the current financial year.

In a break-up, PFRDA said there are nearly 1.45 crore subscribers under APY and the remaining 1.20 crore have NPS accounts.

"The number of subscribers has now touched 2.65 crore and we have just crossed the Rs 3-lakh crore asset under management. Last year (fiscal), the corpus grew almost 40-45 per cent. This year also, so far, it has been good. "Typically, February and March are the busiest months for us. So, we expect to touch similar levels this year as well," said Hemant G Contractor, chairman of the Pension Fund Regulatory and Development Authority (PFRDA).

Talking about the new pension scheme announced by the government in the Interim Budget 2019-20, Contractor said it is similar to APY and can be considered a scheme parallel to it. The Pradhan Mantri Shram Yogi Mandhan (PMSYM) scheme provides for an assured monthly pension of Rs 3,000 with a contribution of Rs 100 per month for workers in the unorganised sector after the retirement age (60 years).

This new government scheme is like APY. The only difference being is that it is only a Rs 3,000 pension scheme. In this scheme, the govt co-contributes up to 50 per cent of the total corpus which is not the case with APY, Contractor said on the sidelines of a PFRDA conference on NPS here Monday.

"In APY also, the pension is guaranteed by the government. The only major difference is the contribution up to 50 per cent by the government (in Pradhan Mantri Shram Yogi Mandhan yojana). This is like a parallel scheme to existing schemes," Contractor said. APY, mainly targeting the unorganised sector employees, offers five slabs of pension from Rs 1,000-5,000 per month upon retirement. Employees in the age bracket of 18-40 years can sign up for an APY account.

PMSYM, which is being implemented by the labour ministry, will not be applicable to those employees who already have an NPS account, Contractor said. NPS is a voluntary, defined contribution retirement savings scheme for government employees as well as for those working in the organised and unorganised sectors.

**Source**

***TOP***

## *Why PPF, the postal investment option, is the best recurring deposit you can have – Financial Express – 18th February 2019*

Run under the Ministry of Communications, India Post offers nine small saving investment schemes, including the Public Provident Fund (PPF) and Recurring Deposit (RD) saving schemes, according to its website, indiapost.gov.in. Post office PPF and RD are the two schemes that can be opted for regular deposits. These schemes are popular as an investment option by customers because both can be started with minimal investment amounts.

Though you can opt for either of these if you want to invest in a recurring deposit, the features and benefits vary. For instance, Post Office Recurring Deposit is a 5-year scheme, whereas PPF comes with a maturity period of 15 years. PPF also offers tax deduction u/s 80 (C). The interest rates are decided by the government every quarter.

**If you are planning to invest, know the best recurring deposit you can have:**

PPF offers attractive interest rates to the investor, which are decided by the government every quarter.

Currently, it offers interest rate at 8 per cent, whereas the 5-Year Post Office Recurring Deposit is offering 7.3 per cent interest. PPF's tax-free status gives it a distinct advantage, unlike RD, where there are no income tax benefits extended to RD investors. The only drawback being the cap of Rs 1.5 lakh on the annual investment by an individual. One can open a PPF account with a minimum of Rs 100 and a maximum of Rs 1.5 lakh.

Another benefit is PPF comes with a long maturity tenure. From the first investment, the maturity period is 15 years, which can also be extended for a further 5 years and so on, within one year of maturity. According to India Post, while you can deposit in an RD account on a recurring basis, there are restrictions on withdrawal before the end of the term. For instance, Post Office RDs are for a tenure of 5 years only. Premature withdrawals can also result in a reduced rate of return.

In case of PPF, after the 15 years' tenure, you can either withdraw the corpus, continue investing in the account or continue with the account without further contributions. However, if you choose to continue investing, an application for extending the account tenure for a block of five years needs to be submitted. Within a year from the maturity date, the application 'Form H' has to be submitted. After five years, you can further extend for another five years.

If you do not submit Form H for tenure extension, your account tenure will automatically get extended, but you cannot make further contributions to it. The balance, however, in the account will continue to earn interest. Once this option of continuing without contribution has been selected, you cannot make alterations to the account.

PPF is mostly popular among risk-averse investors who look for assured returns. PPF also suits non-salaried people who are not eligible for retiral benefits. Experts believe that PPF may not be the best option for young professionals looking to save tax. Other tax-saving instruments may give higher returns, such as ELSS funds.

***TOP***

**Source**

## *Good News for NPS subscribers! Minimum assured return on the anvil from PFRDA - Financial Express – 18th February 2019*

Subscribers of the National Pension System (NPS) may soon get the discretion to choose the fund option that comes with a minimum assured return. Currently, the returns in NPS are linked to the performance of the underlying securities such as equity, debt or a mix of both.

The Pension Fund Regulatory and Development Authority (PFRDA) has invited an Expression of Interest from leading Actuarial firms for designing and development of a Minimum Assured Return Scheme (MARS) for NPS subscribers. The firms have been asked to design, develop and recommend a minimum assured return scheme that can be implemented under the NPS architecture.

**Will guarantee make NPS a defined benefit scheme**

NPS was initially conceived as a contributory pension scheme for Central government employees, replacing the erstwhile defined benefit (DB) scheme w.e.f 01.01.04. Now NPS (defined contribution) caters to all the citizens of India, from the year 2009. Going forward, under MARS, the nature of the

returns may not be a fixed return, instead it will be a minimum return over a specific period. Any shortfall will be made good by the sponsor of the scheme. If a fixed return is guaranteed, then it takes some features of the DB scheme, but is not a DB scheme completely.

Even if MARS gets implemented, there may be a guarantee reset period (Quarterly / half yearly /annual) or any other time period that is recommended and that strikes a balance between subscriber interest and the Pension Funds who need to offer such a product.

The PFRDA Act 2013 clearly states that there shall not be any implicit or explicit assurance of benefits except market-based guarantee mechanism to be purchased by the subscriber.

**Challenges**

The major difference between the government subscribers and other subscribers i.e. under the All Citizens model is that all citizens are not entitled to any contribution of 10 per cent of salary ( enhanced to 14 per cent recently) which is available to employees of government and corporates. What kind of lock in for the MARS would be appropriate (5/7/10 years) keeping in view of the peculiarities of the various government sector subscribers, if a lock in period is required remains to be seen.

Further, under MARS, the recommended scenarios for investment mix (short term, long term and others with bifurcation of money market instruments, G-sec, Corporate debt and equity) will have to carefully established. Also, the quantum of fee or the guarantee charge recommended for the MARS needs to be designed.

**Current structure of fund options**

Presently, in NPS, there are five pension fund managers (PFMs,) two investment options (Auto or Active) and four Asset Classes. The Subscriber first selects the PFM, and post selection of PFM, subscriber has an option to select any one of the Investment Options.

There are four Asset Classes (Equity, Corporate debt, Government Bonds and Alternative Investment Funds) from which the allocation is to be specified under single PFM.

Asset class E -Equity and related instruments
Asset class C -Corporate debt and related instruments
Asset class G -Government Bonds and related instruments
Asset Class A -Alternative Investment Funds

NPS Scheme- E (Tier-I) 5-Year CAGR returns : (As on January 31, 2019)
The NPS fund performance depends on the performance of the underlying asset classes.
SBI PF: 13.25%
LIC PF: 11.44%
UTIRSL: 13.59%
ICICI PF: 12.87%
RELIANCE PF: 12.38%
KOTAK PF: 12.92%
HDFC PF: 13.60
BIRLA PF: Not Applicable

**Conclusion**

Guarantees always come with a cost. Further, in order to provide guarantees, the fund managers need to employ strategies that may not be able to utilise the full potential of equities, which have shown to generate high inflation-adjusted return over the long term than other asset classes. MARS may help to set a floor for the value of savings of the subscribers but may fall short of generating a corpus adequate enough to supplement retirement needs. Ultra conservative investors may, however, find solace under MARS.

TOP

Source

## *India: National pension fund chief targets increased coverage – Asia Insurance Review*


The chairman of the Pension Fund Regulatory and Development Authority (PFRDA) has said that his focus currently is on expanding pension coverage in the country.

Mr Hemant Contractor told the international money management newspaper *Pensions & Investments* that he would worry later about whether India's citizens are saving enough to live comfortably in retirement.

"Adequacy at the moment is not the prime concern," said Mr. Contractor, who oversees India's INR2.7trn ($38bn) National Pension System.

"Our focus currently is on expanding coverage as much as possible ... trying to see that everybody has some pension coverage or the other," he said in a recent interview.

PFRDA's near-term target is to expand the portion of India's population formally saving for retirement to 25% by March 2021 from about 15% at present, he said. The longer-term goal is to cover everybody, he said.

To this end, the government launched on 15 February an ambitious social pension scheme called Pradhan Mantri Shram Yogi Maan Dhan (PMSYM) to cover 100m informal sector workers in five years. The scheme, announced on 1 February by Finance Minister Piyush Goyal in the Interim Budget 2019-20, is implemented by the Labour Ministry. It targets unorganised sector workers with a monthly income of up to INR15,000 and who are aged 18-40.

PMSYM is a voluntary and contributory pension scheme on a 50:50 basis where a monthly age-specific contribution shall be made by the beneficiary till age 60, while an equal amount is put into his or her account by the government. From the age of 60, he or she will receive a minimum pension of INR3,000. Those who already subscribe to the NPS, the Employees' State Insurance Corp Scheme or Employees' Provident Fund Scheme are not eligible for PMSYM.

The NPS was launched in 2004 as a mandatory defined contribution system for new government employees. In 2009, the NPS was opened up as a voluntary retirement savings scheme for all Indians aged between 18 and 60, including those in the informal sectors of the economy. Low income savers account for 3% of NPS' assets. State and central government employees contribute to 85% of the fund's portfolio.

***TOP***

**Source**

## IRDAI CIRCULAR

List of corporate agents registered with the authority as on 31 Jan 2019 available on IRDAI website.

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**Source**

IRDAI issued draft guidelines on standardization of individual health product.

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**Source**

Gross direct premium underwritten for and upto the month of January 2019 is available on IRDAI website.

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Source

## GLOBAL NEWS

### *Engineering, suretyship are biggest growth factors in Indonesia insurance – Asia Insurance Review*

The Indonesia government has been making a big push towards infrastructure building, which has opened up new growth avenues for insurers, said Indonesian insurance and reinsurance brokers' association APPARINDO Chairman Harry Purwanto. "With reference to the OJK's stats, the biggest growth area we can see are in engineering and suretyship."

There are many opportunities for brokers in Indonesia as well, he said. "The domestic retail market has not been fully optimised, and the level of broker penetration is currently only concentrated in major cities on the island of Java."

These opportunities also come with challenges. Even as the Indonesian government pushes to improve Indonesia's infrastructure and economy, they have been strict with regulations and global standards have also had an impact on the industry. Digitalisation, Mr Purwanto said, is a challenge for brokers and insurers, as keeping up with technology adoption of the consumer is a difficult race.

"In general, Indonesian brokers have not developed ways to cope with digital transformation that is currently ongoing. The Indonesian brokers association is currently preparing recommendations to the OJK on these issues," he said.

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### *Australia: Reform of default insurance in superannuation faces challenges – Asia Insurance Review*


The Morrison government is trying to change life insurance in superannuation from a default basis to an opt-in for superannuation accounts with low balances and young new members.

Assistant treasurer Stuart Robert introduced a Bill yesterday aiming at putting this into effect. He said that although insurance provided a great benefit for some people, the cost often eroded entire superannuation accounts for those with low balances, reported Australian Associated Press.

The proposed legislation would make all insurance opt-in for accounts with balances below A$6,000 ($4,300) and for new members under the age of 25. The Treasury Laws Amendment (Putting Members' Interests First) Bill 2019 requires superannuation funds to only offer life cover to young members and those with low balances, where they have opted in to it from 1 October 2019.

However, the Bill faces a challenge from the opposition Labor Party which wants to create exemptions for some categories of workers, including those in risky industries and young single parents, while the Greens Party wants insurance to be opt-out for everyone. In addition, with elections expected to be held in May, there is seen to be no time to amend the law.

Treasurer Josh Frydenberg and Mr Robert issued a joint statement yesterday, saying that the proposed legislation is to protect Australians from paying premiums for insurance "they don't want, need or even know they have".

It means the hard-earned retirement savings of millions of Australians will be protected from undue erosion through inappropriate insurance arrangements. Recent data indicate, of the 11m Australians with insurance in superannuation, around 2.5m individuals have duplicate cover. Of these individuals, over 10% are under 25 years old.

The statement points out that the government's reform will not prevent anyone who wants insurance in superannuation from being able to obtain it – members will still be able to opt in.

The statement says that this change and other superannuation reforms passed by the Parliament earlier this week, will see 5m Australians have the opportunity to save around A$3bn in insurance premiums. Reforms already passed will also see exit fees banned and excessive fees on certain accounts capped.

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## *Four barriers to proper data analytics in insurance – Asia Insurance Review*

There are many barriers to overcome when an insurance company wants to adopt good data analytics, but it boils down to four essentials - the legal system, the analytics schemes, work flow and culture.

"Key amongst all of those is the data input system organisations employ," said IBM's leader for cloud private for data, Mr Samit Mandal, at the 4th Asia Conference on Big Data and Analytics for Insurance yesterday morning. "Data is lying in silos; we have structured data, unstructured data, social data, so on and so forth. And the challenge is bringing them together, while retaining the lineage of the data and be able to analyse it."

Different departments within an organisation might have different preferences for analytic tools, which causes issues in terms of coherent and cooperative workflow. Further, many systems also lie in silos and are not integrated.

Mr Mandal, who was chairing the conference, pointed out that 75% of large enterprises will have digital transformation at the centre of their corporate strategy within the next two years. "However, the problems are immense because 81% of businesses have issues preparing data required in an AI or machine learning project; what we see is that 80% of the data is not clean, leaving only 20% usable in creation of projection models."

Google's head of data platforms Catherine Candano elaborated on the problems insurers have in trying to sift through the vast amount of data and extracting relevant, actionable information. "You don't have a data lake. You have a data ocean. And not many swimmers are proficient in figuring out what to look out for. The question is not so much that we have a lot of data, but what are the things that we should be asking if we had a microscope."

The core things insurers want to look for are to ask questions: "Number one how I use my data to drive as much efficiency as possible? Any time there's friction in a journey of a customer who is considering a policy, how do we remove that? How do we make sure that our data creates value?" she said.

She advised bringing the right kind of data together so that it enhances the visibility or fidelity over a customer's purchasing experience. Touch points such as call centres or customer services centres, warehousing are valuable sources, as well as third party data from partners, such as banks, travel providers, automobile manufacturers or health providers.

"And most importantly you start to think about your digital data, because what's interesting about digital data is that it comes in faster. Every single second is someone searching a mobile phone. You can collect that. It's a lot, but that also means you're basically building a user graph, the journey of a customer," she said. The conference was organised by Asia Insurance Review and sponsored by ReMark.

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