Insurance Institute of India
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INSUNEWS

- Weekly e-Newsletter

2nd – 8th June 2018

• Quote for the Week •

"Failure is simply the opportunity to begin again, this time more intelligently."
Henry Ford

INSIDE THE ISSUE

Insurance Industry

Boosting non-interest income: PSBs under PCA tie up with insurers and MF aggregators – Financial Express – 8th June 2018

With curbs on lending, bond yields shooting up and a limited portfolio of non-core assets to monetise, the smaller public sector banks (PSBs) under the Reserve Bank of India's (RBI) prompt corrective action (PCA) framework are relying on non-credit products, such as insurance and mutual-fund distribution, to boost their income.

Earlier this month, Kolkata-based UCO Bank floated a request for proposal (RFP) for the selection of life insurance companies for a corporate agency tie-up for its bancassurance business. At present, it has such a tie-up with state-owned Life Insurance Corporation (LIC) of India only.

UCO Bank's RFP follows a similar move by Mumbai-based Dena Bank, where RBI banned fresh lending last month. On May 24, Dena Bank had sought bids from corporate agencies to increase its portfolio of providers of health, general and life insurance products through the bancassurance channel.

A senior executive at the bank had told FE that the move was aimed at increasing third-party income without affecting its anaemic capital base. "We already have certain arrangements on this front. The Insurance Regulatory and Development Authority (Irda) also allows us to add more partners. So, we are looking at that possibility to augment our third-party income," the banker had said.

Currently, Dena Bank counts as its partners LIC for life covers, United India Insurance Company and Chola MS General Insurance Company for general insurance, and Apollo Munich Health Insurance Company for health covers. Late last year, Pune-based Bank of Maharashtra (BoM) shortlisted Reliance Nippon Life Insurance Company and Aviva Life Insurance Company for insurance tie-ups. BoM was brought under PCA in June 2017.

Investment advisory is another channel through which banks under PCA are trying to support their income. On June 1, Gurgaon-based Oriental Bank of Commerce (OBC) floated a tender seeking a corporate tie-up with an online mutual fund aggregator, investment service provider and robo advisory service provider. These services will be offered to the bank's new and existing customers.

"The engagement pre-requisite is to provide the online mutual fund aggregator services platform along with the robo-advisory services, which shall be later enhanced to offer other investment options/avenues using the common interface, thereby creating a one-stop solution for investment services," OBC said in the tender document. At present, the bank has tie-ups with seven asset management companies for driving the mutual fund business, primarily through its branches in an offline mode. Smaller banks relying on non-credit products to boost their income.

Source

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Bank-led private insurers to gain more market share – Financial Express – 8th June 2018

Strengthening bancassurance channel for private players and customer preference shift towards ULIPs have led to private players gaining 20% retail business market share from LIC over FY12-18. Those with strong bancassurance channel have benefited the most. We expect bank-led private insurers to continue to gain market share.

LIC's share in total APE (annualised premium equivalent) has come down to ~50% currently from >60% in FY12. Market share loss has been the most prevalent in retail/ individual business segment, where LIC's share has reduced to 44% in FY18 v/s 63% in FY12.

In group (B2B) business, LIC has consistently maintained 80% market share. Within the private players, biggest gainers of retail APE market share have been insurers with strong bank-led distribution. SBILIFE, IPRU and HDFCLIFE have gained 8%, 6% and 2% retail APE share respectively over FY12-18.

Post 2010 regulations, ULIPs (with stringent cap on surrender charges) offer better value proposition. High penalty in non-linked savings implies capital loss to policyholders surrendering even at the end of 5th year v/s nil surrender charges on ULIP after five years. Better product structure along with supportive capital markets have led to policyholder preference shift towards linked business, which is primarily dominated by private players and LIC has negligible presence.

More than 60% of LIC's new business premium comes from group business, primarily employer-employee fund management business. Even though ticket sizes are higher, this business runs on wafer-thin margin. Private players are also present in group savings, but they maintain caution in limiting its share in overall business since –

Source

(a) LIC is the price maker in the industry with most other players being price takers
(b) Being non-participating, interest rate sensitivity is high.

Back

Make insurance part of school curriculum: IRDAI official – The Hindu – 7th June 2018

A senior official of the Insurance Regulatory and Development Authority of India (IRDAI) underscored the significance of including insurance in school curriculum.

"Time has come to consider making insurance a part of the school curriculum, so that children are exposed to its benefits and understand the need for it very early in life," said Sujay Banarji, Member-Distribution of IRDAI.

Addressing a seminar on insurance here on Thursday, he said insurance in school curriculum would also help create awareness of career opportunities that the sector offers.

The seminar was organised by PHD Chamber of Commerce and Industry and insurance firm IFFCO-TOKIO trade and industry body FTAPCCI here.

Mr. Banarji said this while providing details on the insurance sector in the country, especially its growth. The premium underwritten has increased from Rs 61,150 crore in 2001-02 to Rs 3,44,500 crore as on March 31, 2018, of which life insurance share was around Rs 1,93,000 crore, while that of general insurance was Rs 1,50,000 crore.

The scope of growth was huge, he said, pointing out that the insurance penetration was around 3.44% in 2016-17, while the global average was more than 6%.

On grievance redressal, he said all the insurance companies made the best effort that the complaints and servicing of the policy-holders were taken care of. He appreciated the Telangana government for its initiatives to promote insurance.

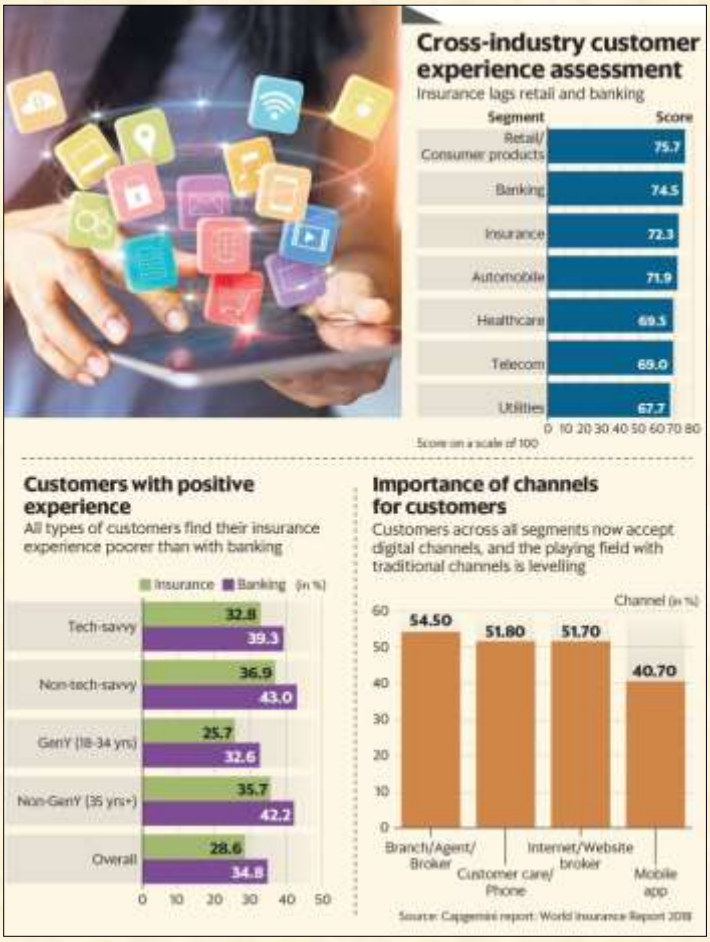
Source

Finance Minister Eatala Rajender, addressing the gathering, highlighted the achievements of the State government in the last four years, including a proposal to provide insurance cover to farmers.

Back

Insurance trails behind banking, retail on customer experience – Mint – 6th June 2018

When it comes to delivering superior customer experience, the insurance industry is placed third behind retail (consumer products) and banking. A report on a cross-industry customer experience assessment by Capgemini and Efma—World Insurance Report 2018—revealed that while insurance is performing better than average, increased customer engagement efforts may lead to parity with front runners such as retail. With a score of 72.3%, the insurance industry trailed retail (consumer products) and banking, which garnered ratings of 75.7% and 74.5%, respectively.



Within financial services, insurance trails banking across various parameters such as overall customer experience, customer satisfaction, and being proactive. While 32.6% of Gen Y (individuals aged 18 to 34) and 34.8% of tech-savvy customers had a positive experience with their bank, only 25.7% of Gen Y and 28.6% of tech-savvy customers said their insurance experience was positive. In short, insurers must adopt emerging technology to leverage its customers and expand their business by breaking traditional customer-interaction limitations.

Digital channels are catching up with traditional channels. More than 55% of Gen Y and tech-savvy customers cited the internet as an important insurance transaction channel. Value-added services are being targeted by new entrants. As digitally-agile, multinational BigTechs gradually enter the financial services' space, insurers must prepare to counter the challenge. BigTech firms such as Google, Amazon, Facebook and Apple have certain advantages and they can enter the insurance industry with new tech-based disruptive models. Customers, too, say they would consider buying insurance from BigTech firms, with 29.5% of global customers willing.

Source

The report covers three insurance segments—life, non-life, and health insurance. It draws on research insights from 2018 Global Insurance Voice of the Customer Survey and 2018 Global Insurance Executive Interviews, which together covered 26 markets, including India.

Back

Insurance firms knock off agents, go for digital-first to grow business - Business Standard – 4th June 2018

Insurance is a business of relationships; traditionally, an outcome of frequent handshakes between agents and their customers. That is changing fast. Some of the country's biggest insurers are moving to a digital-first approach, reducing the dependence on agents for selling an insurance product.

Take the case of Edelweiss Tokio, one of the latest entrants to the insurance space. The company thinks of itself not as an insurance company but a technology company in the insurance business and that makes all the difference, according to its Chief Retail Officer Anup Seth.

Seth said that the company has adopted a completely digital policy even for its offline channels such as agents and company distributors.

"Digital has not only given the customer the power to access information as per his convenience. In addition, the use of digital and analytics tools like AI have helped improve the recommendations and enhance customer experience," he said.

This also reduces the arbitrage of only those policies being sold which appear attractive to agents. "Offline businesses are depended on the agents' competency and how he sees the product in his mind. Digital has taken that arbitrage away by giving him the clear idea. Agents no longer end up selling what they want to sell," said an insurance industry professional.

Edelweiss Tokio has a full stack of digital applications. For instance, an instant policy issuance which converts a customer's money into a policy in 30 seconds. And, a unit-linked insurance plan invests the money in the market the same day the policy is purchased. The way companies are approaching digitisation is two-pronged. Not only are they intent on boosting their online sales, they are also focused on making their field executives digitally savvy via a range of tools, which use algorithms and machine learning to predict what a customer might want even before the latter expresses a desire.

"The list of prospects is run through an algorithm; it tells you which five of the 40 you put are more likely to buy insurance if they are told a certain story. We have started to run a predictive model. However, this can be done only when the agent has information like estimated income range, age, life stage, etc," said Manik Nangia, chief digital officer at Max Life Insurance.

Max Life says its app is so built that no task takes more than 90 seconds at the agent's level to get completed. The app also has 'nudges' – it shows agents the best performers in their city and their premium value, so that people are motivated to do more and compete while bringing in more business. This is perhaps why one in every five customers for Max Life comes through the digital medium.

Private life insurer SBI Life has to reach State Bank of India branches across the country and also service regional rural banks through its bancassurance partners. The company says 70 per cent of the bancassurance business is done online, through an application called ConnectLife. This is used as a digital proposal form and conducts everything from a need analysis to customer onboarding and digital payments.

"Once the customer agrees on a recommendation, the data goes into something called the customised benefits illustrator -- it tells the customer how the policy will look like in its entire tenure," said Anand Pejawar, the company's president for operations, IT and international business. "We also have an e-signature that can be attested on the benefits' illustration. The application form then gets auto-filled, based on e-KYC, NSDL's PAN verification and credit bureau data based on PAN information."

When it comes to processing of claims, HDFC ERGO is emerging as a big user of artificial intelligence. The company is using machine learning as well to process hospitalisation claims faster. The average time taken for a claim to be processed and consumer discharge is now 17 minutes, says Mehmood Mansoori, head of its IT marketing & online business.

Similar innovation has been rolled out by the company in motor insurance claims. "No longer there is a need to send a surveyor to inspect your car. We send a link to the customer and the customer does the survey through his own phone and uploads it to us. Within an hour, we are able to accept or reject, for up to Rs 20,000," he said.

Source

"In the process of changing the character of the organisation, we would like to call ourselves a fintech company. Today, experience from an insurance house is expected the same way as from Amazon or Netflix," added Mansoori.

Back

Insurance Regulation

India to help Myanmar in insurance laws, GIC to assist authorities - Financial Express – 7th June 2018

The General Insurance Corp of India (GIC) will assist Myanmar authorities in amending laws related to insurance and reinsurance and in expanding insurance services in the country, authorities said here on Thursday.

Reinsurance is the practice of insurers transferring portions of risk portfolios to other parties by some form of agreement to reduce the likelihood of paying a large obligation resulting from an insurance claim, Xinhua news agency reported. It is also known as an insurance for insurers.

Source

In accordance with the agreement signed by the two sides, the GIC will provide assistance to Myanmar authorities. At present, Myanmar Insurance offers 29 types of insurance including those related to health, car, homeowners, life and disability.

India: Regulator wants agents' data uploaded to central database – Asia Insurance Review

The insurance regulator IRDAI has directed insurers as well as insurance marketing firms (IMFs) to upload details of individual agents and insurance sales persons into a central database of the Insurance Information Bureau of India (IIB) by this month.

The second phase of the database, called Envoy, is ready, the regulator said in a recent communication to insurers and IMFs, asking them to upload the details in the prescribed format, according to a report by *The Hindu*. The number of individual agents with life insurers exceeded 2.09 million at 31 March 2017.

The IRDAI had announced in August 2017 the setting up of the central database at the IIB. In the first phase, all insurance intermediaries were advised to upload details of qualified persons, specified persons and authorised verifiers, on the database of the Bureau.

The measure is primarily aimed as a check against duplication. Explaining the rationale behind creating the database, IRDAI had said this was to ensure that "all licensed insurance sales persons working for insurers and intermediaries... do not work with multiple insurers/ insurance intermediaries in the same business category". Figuring in the database are agents, broker qualified persons, specified persons of corporate agents, authorised verifiers of web aggregators and point of sales persons (POS).

A search facility is available on the ENVOY portal for insurers and insurance intermediaries to check details regarding a prospective candidate. "The appointment of such a person by the insurer or insurance intermediary shall be taken up only after ensuring that the applicant does not already figure in the database," the IRDAI said.

Source

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Life Insurance

Life Insurance: Ulips, term protection plan to lead life insurance market – Financial Express – 8th June 2018

India's life insurance sector has been on a roller-coaster ride. While the structural growth opportunity is large and promising (favourable demographics, increasing financialisation and a large protection gap), near-to-medium term risks exist from regulating product structure, pricing and protecting policyholders' interests. These factors could dent profitability —in particular, the disproportionately higher pricing in credit protect, and high surrender penalty for policyholders in non-linked savings.

Regulatory clampdown

We foresee the risk of regulatory clampdown on credit life, where disproportionately higher prices (at least 3-4x of a comparable pure term) lead to a poor value-for-money for the policyholder. It has been the fastest growing segment for private players and is contributing 4-13% of current new business value (VNB). Higher margins in the segment are attracting competition and pushing up the distribution costs.

Our checks suggest 15-20% first year opex. ratio (on single premium), whereas commission costs should be lower as IRDAI caps commissions at 5%. Our channel checks suggest 60-80% attachment rates for some of the home finance lenders and thus, chances of mis-selling/forced selling cannot be ruled out. Margin erosion or slower growth in this segment will affect HDFC Life the most (13% contribution to VNB).

Non-linked savings

We believe that a large part of new business profits from par-savings comes from surrender charges. High penalty implies capital loss for policyholders surrendering even at the end of fifth year. (v/s nil charges for ULIPs after 5 years). This is a well-recognised concern and even highlighted in IRDA's product regulation committee.

Focus on underinsured

We don't believe life insurance in India is as underpenetrated as it is usually perceived, and there's no reason it should be, given the largest player LIC has existed for over six decades. Having said that, growth opportunity lies in catering to the under-insured.

Our calculation suggests that more than 50% of targetable lives are already under the insurance net, but average sum assured is only about Rs 3,00,000 per policy. Our new business premium growth expectations for overall industry is at around 15% in the medium term.

Banca-led players to gain share

We believe that the dominance of players having strong bancassurance channel shall continue. Drivers of bancassurance channels' success are two-fold —distributor bank's equity stake in the insurance subsidiary and prevalence of standardised insurance products. Hence, even as industry growth tracks at 15%, business growth for those having strong bancassurance channel will be higher.

Shift towards Ulips, term protect

We believe that business mix for private players will gradually shift towards unit-linked insurance policies (Ulip) for savings and pure term for protection. Post-2010 regulations, Ulip (with stringent cap on surrender charges) offers better proposition for policyholders than traditional par savings.

Private players catering to upper end of customer segment who have a better understanding of equities and prefer term plans for protection needs, and impending risk of surrender charges being rationalised in traditional par and non-par savings.

Source

Back

T insures each farmer's life with Rs 5L - The Pioneer – 5th June 2018

Telangana became the first State in the country to launch first of its kind free life insurance scheme for the farmers. The State Government on Monday signed a Memorandum of Understanding with the Life Insurance Corporation (LIC) in Hyderabad under which the State Government will pay the premium for all the policies of farmers and in case of death of any farmer due to any reason the LIC will pay Rs 5 lakh to his or her nominee. Speaking on the occasion the Chief Minister K Chandrasekhar Rao said there should not be any doubt that his Government was partial towards the farmers. "After the path breaking Ryhtu Bandhu scheme, this is another major step for the welfare of the farmers in Telangana", he said.

Life Insurance Corporation Chairman VK Sharma lauding the insurance scheme for the farmers called the Chief Minister KCR a "friend of farmers and a visionary leader". "I am also from farmers family and worked in many parts of the country but have not seen a insurance scheme like this anywhere in the country", Sharma said. He pointed out that LIC had already invested Rs 40,000 crore in Telangana.

The insurance scheme will cover all the farmers in the age group of 18 to 60. While under the Rythy Bandhu scheme, every farmer will get Rs 4000 investment support per acre per crop, the insurance scheme will help the family of any farmer after his death. "The purpose of both the schemes was only to see the farmers in the State happy", KCR said. "the farmer who feeds the people should be satisfied. The country will progress only when the farmers are happy".

The insurance scheme will come in to effect from August 15 and in case of death of a farmer, his family will get the claim within ten days.

The Chief Minister directed the agricultural officers to ensure that the filled in form of every farmer was submitted to LIC before August 15 with the correct names of the insured person and his nominee and other details. He also wanted the officials to ensure that the farmers raise only those crops for which there was a demand in the market.

KCR said that he as a farmer had not taken the cash benefit under the Rythy Bandhu scheme and had asked the other famers with big income to do the same. "But now I will surely take the insurance scheme and ask all the farmers to take it", he added. KCR said that if quality power was available, water is available and minimum support price was assured the farmers would not face any problem. "But unfortunately fixing the MSP for crops was not in the hands of the State Government".

Quoting a report the Chief Minister said that of the 57 lakh farmers in the State, 89 per cent were happy with the Rythu Bandhu scheme. There were 32 lakh farmers who own 1 or 2 acres of land in the State.

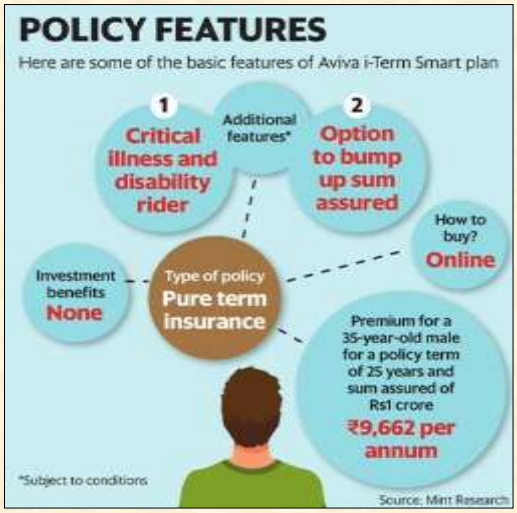
Source

Telangana already has made a name for various unique initiatives to help the farmers including the 24x7 free power supply.

Buying a term insurance plan? Compare features, not just premiums – Mint – 4th June 2018

If you want life insurance then don't look beyond a term plan: it's the cheapest and the best way to insure your life and now you can buy it online. With the online platform making term insurance popular, insurers are coming up with various innovations to make it more attractive.

Innovations allow you to customise your plan. For instance, if you think your dependants will not be able to use the lump sum well, you can break it into smaller amounts to ensure periodic income for them. You could also choose to pay a part of the sum assured as lump sum and pay periodic income with the rest.



Given the customisation options, now you should also look at the features of a term plan and not just its premium.

Aviva Life Insurance Co. India Ltd recently added Aviva i-Term Smart plan to the stable of online term plans.

What is it?

It's a plain vanilla online term plan. The policy will calculate the premium depending on the sum assured and factors such as your age and term.

Like other term plans, this one allows you to pay annually, semi-annually and monthly. On death of the policyholder during the term, the nominee gets the sum assured and the plan terminates. There are no maturity benefits and if you choose to surrender, you don't get any surrender value either.

This plan only offers the lump sum payment option. "We also have a feature rich term plan that offers periodic income benefit. Our experience suggests that too many features tend to confuse customers when they are looking for a simplified solution, especially in this category.

Hence, we have designed a simple proposition which the customer understands clearly," said Sapan Sane, product head, Aviva Life Insurance Co. India Ltd.

The plan comes with the option of a rider, an add-on insurance to a base policy. You can opt for a critical illness and disability rider, which covers 16 critical illnesses and total permanent disability. The sum assured under the rider can't exceed the base sum assured.

The premiums are subject to revision every five years. The premiums for the base term plan will remain fixed though.

The policy also allows you to increase the sum assured on certain events like marriage, child birth, or taking a home loan or in the fifth year of the term.

However, you can do this only once during the term and not in the last 10 years of the term. The sum assured can go up only up to Rs 25 lakh and the policyholder should be less than 45 years of age when doing it. While the insurer will bump up the sum assured without any medical examination, a new premium will apply.

Mint Money Take

Suppose a 35-year-old male buys this product for a policy term of 25 years and for a sum assured of Rs 1 crore, the annual premium will come to Rs 9,662. This is not the cheapest in the market, but the premiums are very competitive.

According to Suresh Sadagopan, a Mumbai-based financial planner, the premium is not the only thing to look at. "Premium becomes important if the gap is very big.

One needs to look at the features and the claims settlement ratio of an insurer," he said. "From a family point of view, plans that allow you periodic payment are better as it limits misuse of funds," he added.

Source

In FY17, Aviva settled 91% of the claims going by the policy number and 84% going by the value. In both cases, there are companies that have a much higher settlement record.

General Insurance

Permits key to claim insurance: SC – The Hindu – 6th June 2018

Insurance companies are not liable to compensate accident claims for public transport vehicles plying without permits, the Supreme Court has held.

'Permits' are authorisation given by State authorities to use motor vehicles as transport vehicles "Use of a vehicle in a public place without a permit is a fundamental statutory infraction," a recent judgement by a Supreme Court Bench of Chief Justice Dipak Misra and A.M. Khanwilkar observed.

The verdict came on an accident involving a truck which fatally hit a two-wheeler rider in February 2013 at Pathankot. The insurance company argued that the truck was used in violation of the terms of the insurance policy. The driver did not have a valid driving licence and, therefore, it was not obliged to indemnify the insured. That apart, a stand was taken that the vehicle did not have the permit on the date of the accident.

The verdict said the existence of a permit of any nature is a matter of documentary evidence, but nothing was brought on record by the insured to prove that he had a permit of the vehicle.

Source

"In such a situation, the onus cannot be cast on the insurer," the apex court decided while dismissing the appeal against the company.

Back

Title insurance: Much-needed relief for home buyers - The Economic Times – 5th June 2018

Title refers to the legal right to a property which is obtained by a requisite registered document. Every time a property changes hands there is a change in the title as well. Somewhere in the chain of transfers and transmissions of the property, certain lacuna prevails and some defect in the title is observed.

The issue of ownership/title is a large-scale problem in the real estate market. The maxim of law "no one can give better title than what he has" (nemo dat quod non habet) is the basis on which most of the title disputes are formed. In other words, a defective title holder cannot pass on a valid title to his buyer.

This is where having title insurance will help. Title insurance is fundamentally encompassed under the recent contemporary legislation, the Real Estate (Regulation and Development) Act 2016 (RERA), which is premeditated to shield the interest of the owners, investors including but not limited to lenders against any shortcoming in the title to a property.

Title insurance is something that is much-needed in the real estate industry and it will unquestionably comfort the sentiments of buyers on one hand, and developers, lenders, and institutional investors on the other.

What is title insurance?

Title insurance is an insurance of indemnity and unlike other insurances, it has a retrospective effect. This means, the title insurance indemnifies the insured against all the loses and claims that are suffered by the insured as a result of defect in the title of a property (of which the insured was not aware on the date of the policy) even before the date of the policy. So, in simple words, title insurance means an insurance against any loss caused as a result of defect in the title of the property.

In every real estate transaction, a buyer desires to obtain a clear title and marketable title to the property and intends to know the restrictions or encumbrances on the property before purchasing it. State laws and local restrictions on a property can sometimes hinder the ownership. In every real estate transaction, therefore, emphasis is laid on a marketable title. Even after thorough due diligence, at times there are anomalies in the title of the property that can crop up.

Title insurance is available in many countries such as Canada, Australia, the United Kingdom, Europe etc. In India, title insurance has not been a common practice.

Not many Indian insurers offer title insurance

Indian insurance companies lack the underwriting expertise to offer title insurance products. Indian insurers require reinsurance support to be able to offer the product as the cost involved is high. The menace of defective land records resulting in title complications is relatively high in India.

Challenges with title insurance

The major reasons why insurance companies have resisted developing the title insurance policy product are: -

1. The volume of title related swindles are numerous;
2. The legal redressal for the title disputes is sluggish;
3. The costs involved in conducting due diligence of the property before issuing the policy are substantial;
4. A lengthy and a time-consuming process of conducting searches at the appropriate land registries, inspection of land records maintained in government offices and making such other enquiries as may be necessary to ascertain if there is any encumbrance on the property; and
5. Although the Limitation Act of 1963 lays down period of limitation within which a suit is to be filed, in several instances, the courts condone the delay and this results in great uncertainty with respect to litigations that may arise on a property.

RERA, now, by virtue of section 16, rests the terror of title disputes by employing an obligation on the promoter to obtain such insurances as may be notified by the appropriate Government including but not limited to two kinds of insurances being, insurance in respect of: -

- Title of the land and building; and
- Construction of the real estate project.

The promoter will also be liable to pay the premium and charges in respect of these insurances and shall pay the same before transferring the insurance to the association of the allottees, once the project has been completed. State governments are yet to notify the enforcement of this section.

The mandatory title insurance will condense the title disputes and metamorphose the real estate industry into a resolutely, controlled, and regulated segment.

The principal distress for most of the developers, private equity investors, institutional investors and even purchasers is the risk of objections being raised on the title of the property which consequently makes the ownership debatable rendering its marketability to be truncated and in case of construction projects it even impedes and suspends the construction progress.

Title issues often result in interminable litigations thereby cumulatively increasing the total cost involved in the transaction. The developers in any project are susceptible to plentiful litigations with respect to title of the Land and this inversely affects the consumers as well. It becomes prudent in such cases to have a title insurance.

Obligations of the insured

When purchasing a title insurance, it is vital to read the policy and be aware of the coverage that is provided. As soon as an individual signs the policy, he/she becomes accountable for all the information provided which includes not only the benefits of the policy but also the restrictions contained therein.

Insurances of every kind are subject to several disclaimers. Likewise, a title insurance is also subject to disclaimers. The insurance policy contains exclusions which, if not carefully observed, could lead to failure in claiming the policy money. In addition to the losses covered under the insurance policy, it is equally important to understand facets such as:

a. How the policy can be claimed;
b. The evidence acceptable for proving the loss;
c. The period within which the loss should be intimated to the insurance company;
d. Renewal of the policy;
e. Limit of indemnity etc.

Why you should have title insurance

Title insurance protects investment in real estate and provides coverage against financial loss arising from title defects and other irregularities relating to property acquisition.

Now that RERA has made having a title insurance compulsory, it is going to be of utmost advantage to the consumers as well as the insurance companies. It safeguards all the possible disputes that may arise in respect of the title of the property.

The noteworthy advantages of having a title insurance are:

1. It crystalises the due diligence process;
2. It relatively reduces the risk factor involved in real estate transactions;
3. It accelerates real estate investment;
4. It supplements the representations and indemnities given by the seller in the documents;
5. It covers any defect in title arising as a result of a defective title document; and
6. It covers litigation costs.

Although RERA mandates that the developer shall obtain title insurance in respect of new projects and ongoing projects, obtaining title insurance is a practice that must be followed in the real estate sector as it is a contemporary form of indemnity and need of the hour owing to the fact that property disputes are very persistent.

'Caveat Emptor' or let the buyer beware is the defense taken in most real estate transactions by the developers and the vendors this results in the nightmare of real estate litigation which often petrifies the homebuyers. Having a title insurance will reduce the burden of the prospective buyer, developer/ institutional investor with respect to title of the property as there is thorough check on the title which reduces subsequent risks.

The insurance regulator, Insurance Regulatory and Development Authority of India (IRDAI), in process of formulating rules and regulations to promote and initiate the implementation of title insurance in India. In the light of the efforts put in by IRDAI and the provisions of RERA, it is expected that there will be some progress for the establishment of the concept of title insurance in India.

Source

Although most of the insurance companies are still in the process of building the title insurance product as it will be project specific, once the product floats in the market the demand would be high as it is a superlative form of indemnity and protection which the consumers can have.

Back

Over 4.5 lakh property owners to benefit from free road accident insurance scheme – The Times of India – 5th June 2018

Over 4.5 lakh property owners in the Pune Municipal Corporation (PMC) limits have a reason to cheer. They will be entitled to a special road accident insurance cover of Rs5 lakh for free.

The insurance cover is a reward to these citizens for paying the property tax before the deadline of May 31. The civic body will pay instalments for the scheme.

According to the National Crime Records Bureau, around 400 fatal accidents are reported every year in the city. Nearly 200 — half of the road accident victims — are two-wheeler riders. Over 4,050 people died in accidents in the city, while more than 5,000 were seriously injured in a decade's time.

The free road accident insurance scheme was a part of the Pune Municipal Corporation (PMC)'s budget. It has been named after Pandit Deendayal Upadhyay. The civic body has set aside Rs7 crore for the project.

Dynanewshar Molak, the head of the PMC's property tax department, said, "These people (getting free accident insurance cover) have paid their dues before the deadline. They will get the benefit of this scheme. It was the condition for becoming a part of this project."

Source

The civic body offers discount to those who pay the property tax between April 1 and May 31. It earned over Rs600 crore during this period in the current fiscal. Over Rs52 crore was collected on the last day.

Back

Travel Insurance: Travelling overseas? Don't forget insurance – Here is why - Financial Express – 5th June 2018

While travelling can be relaxing, it can turn harrowing because of any unforeseen circumstances. Travel insurance can cover against unexpected situations such as medical costs abroad, loss of luggage, cancellation or delay of flights, etc.

A comprehensive travel insurance will cover many aspects of your travel and protect your family from any financial or medical emergency. Travel insurance is mandatory for trips to the UK, the US, Austria, Greece,

Portugal, Spain, France and Germany (Schengen). Even where it is not mandatory, it is always beneficial to get one for travelling abroad. If you are planning to take more than two holidays a year, take an annual policy which will be cheaper than a single trip policy.

Insurance companies offer a wide range of specialised travel insurance plans such as family floater, senior citizens, students and multiple trips plans for business travelers. The premium depends on the age of the insured, number of travellers, country of visit, number of travel days and the kind of coverage opted for.

Travel insurance safeguards one against unforeseen medical contingencies abroad. Medical treatment abroad can be very expensive. Do ensure that the expenditure limit attached to your health insurance cover is adequate. A comprehensive travel insurance cover will not only take care of your medical cost abroad, it can bear the cost of flying you back at home under medical care. Remember to declare pre-existing medical conditions before the travel since these are not covered. Most travel insurance policies exclude acts of terrorism, war or war-like actions, suicide and self-inflicted injury.

If you fall sick, inform your travel insurance company as soon as possible for the claim. Do keep both the domestic and international toll free numbers of your insurance company handy. In case of any medical emergency, the insurance company will contact the local medical facilities and offer assistance. If the insurance company is not informed on time, claims can even be rejected.

The usual documentation required includes original bills and invoices of the expenses incurred, payment receipts for all invoices and records of treatments and tests. In case of an accident, you must also provide the FIR document filed with the police. To file a claim, you will need to submit the claim form of your insurance company along with your medical reports and details of the expenses you want reimbursed.

If you are unable to go on your planned trip due to medical reasons you will need a doctor's certificate stating the same and file claim process with the insurance company. You can also file claims for a pre-existing disease if your insurance plan has a pre-existing condition waiver.

Other expenses

Travel insurance covers loss of passport, loss of baggage, missed flights, delay in flights and even natural calamities leading to trip cancellation. In case of lost baggage, file an FIR with the local police and submit a certified copy of the FIR, along with a photocopy of your passport to the insurer. It will pay for your clothing and other belongings. Do check the real value of your luggage before opting for a luggage cover as your cover should ideally cover the real value of your luggage. In case one has lost cash during your travel, he will need to submit the FIR, and documentation of cash withdrawal or traveller's cheques issued.

As flight delays are common these days, one can make a travel insurance claim against the monetary loss. The insurance company will require you to file a copy of the confirmation letter from the airlines clearly stating the duration of, and the reason for, the flight delay. This must be attached with your claim letter for any losses you may have incurred along with invoices of purchases such as for meals, and alternate travel plans that you had to undertake due to flight delays.

Source

Back

Motor Insurance: Long-term third-party cover for new private cars and two-wheelers - Financial Express – 4th June 2018

In order to cover more people under the mandatory third-party motor insurance cover, the insurance regulator has advised companies to design long-term cover for new private cars and two-wheelers. At present, the rates of third-party motor insurance are fixed by the regulator every year depending on the engine capacity.

Long-term covers

The Insurance Regulatory and Development Authority of India (Irdai) note underlines that third-party insurance should be five years for two-wheelers and three years for four-wheelers. Half of the vehicles plying on the roads are uninsured despite the third-party insurance being mandatory. "With a view to ensuring that these uninsured vehicles are covered against motor third-party insurance, the Supreme Court Committee on Road safety is of the view that general insurance companies should issue long term insurance covers, namely five-year policy for two-wheelers and 3-year policy for four-wheelers," the communication from Irdai to non-life companies says.

The regulator underlines that long-term third-party insurance will reduce the hassle of renewing the policy every year, and an increase in the number of insured vehicles could bring down the rates as the risk pool becomes larger. It will also ensure that the policyholder has some stability in rates for a defined period. For insurers, too, such a move will increase the number of insured vehicles and lead to higher penetration and premium volumes. Also, an increase in critical mass could mean better experience.

Tapan Singhel, MD & CEO, Bajaj Allianz General Insurance, says with long-term third-party cover policyholders will not have the hassle for renewing their motor insurance every year. From the industry point of view, he says risk will be high, as during the long terms the laws keep changing and the losses could also go up. "We are awaiting further clarity from IRDAI on how this is going to be priced, since the long term premium can't be priced on the lines of the current one year rates and long term inflation rates will also need to be considered," he says.

Rates fixed by Irdai

For 2018-19, the insurance regulator had reduced the premium rates for motor third-party insurance. The premium for cars with engine capacity of less than 1,000 cc was reduced from Rs 2,055 to Rs 1,850. There has been no change in the existing rate for cars with engine capacity higher than 1,000 cc. Similarly, the premium on two-wheelers with less than 75 cc engine was lowered from Rs 569 to Rs 427. However, the premium on two-wheelers over 350 cc has gone up from Rs 1,019 to Rs 2,323.

Motor insurance comprises own-damage and third-party insurance. Any vehicle that plies on the road needs the mandatory third-party cover under the Motor Vehicles Act and insurers will have to ensure that the policy is available at each of their underwriting offices. To arrive at the new third-party motor premium in April ever year, Insurance Regulatory and Development Authority of India (Irdai) analyses the data on accidents given by the Insurance Information Bureau of India.

The rates are fixed by the regulator depending on the engine capacity and the vehicle owner has to pay the amount every year. No insurer can give any discount on the third-party premium fixed by the regulator. Then, there is own-damage premium which is fixed by the company depending on their underwriting losses and this is where one can negotiate the premium with the insurer.

Third-party liability is decided and awarded by the judiciary taking into account the age of deceased, earning capacity, wages, etc., which keep rising due to inflation and other factors. The Motor Vehicles (Amendment) Act has substantially increased compensation for accident victims.

Considering the mandatory nature of third-party insurance, Irdai had asked insurers to ensure that the cover is made available at their underwriting offices and through all available channels of distribution. The reported claims frequency is the highest for the goods carrying segment, followed by passenger vehicles and private cars.

Policyholders should look at a comprehensive cover which takes care of the own damage portion, especially loss or damage due to fire, explosion, accidents or while in transit by road or rail, and even burglary and theft. A comprehensive motor insurance cover comprises own-damage and third-party insurance.

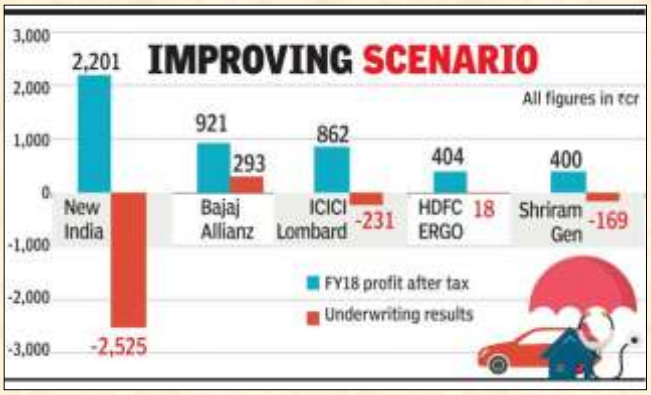
Source

Back

With no disasters, non-life companies see higher margins – The Times of India – 2nd June 2018

In a pointer to improved margins in the general insurance industry, three non-life companies have reported underwriting profits as against only one last year. Underwriting losses — excess of claims paid over premium — have narrowed for most companies, indicating that prices have firmed up for corporate insurance space. Industry numbers for FY18 show that Bajaj Allianz continues to be the most profitable general insurer and has improved margins further.

According to data released by non-life companies in their public disclosures, three have generated underwriting profits — Bajaj Allianz General Insurance (Rs 293 crore), Universal Sompo (Rs 290 crore) and SBI General (Rs 94 crore). Bajaj Allianz is also the most profitable non-life company in the private sector with a net profit of Rs 921 crore — an increase of 26% over the net profit in the previous year.



Bajaj Allianz General Insurance MD & CEO Tapan Singhel said, "Last year, the industry had no major catastrophe. This has an impact of 5-6% on the overall margins. In the past, we have seen floods cause widespread losses on motor portfolio." Another factor that has improved bottom lines, according to Singhel, was the listing of insurance companies, which has shifted focus to margins. The companies that listed in FY18 are New India Assurance, ICICI Lombard and national reinsurer GIC Re.

However, the non-life industry is extremely cyclical and improved margins often lead to more aggression for market share, which leads to pricing coming under pressure. "We have already seen prices coming under pressure during April renewals," said Singhel.

The largest private non-life company ICICI Lombard General Insurance reported a profit of Rs 862 crore — an increase of 22% over previous year. The company has also narrowed its underwriting loss to Rs 231 crore from Rs 318 crore in FY17.

Public sector New India Assurance — the largest non-life company — reported a net profit of Rs 2,201 crore, despite underwriting losses of Rs 2,525 crore. This has been possible because the state-owned insurer has a very large investment portfolio arising out of reserves for claims that must be paid in future. It is the income from these reserves that help offset the claims.

The other three public sector insurance companies — National Insurance, Oriental Insurance and United India Insurance — have not yet declared their results. These three are scheduled to merge following the budget announcement.

Source

Another company that has sharply improved its performance is HDFC Ergo General Insurance, which had earlier acquired L&T General Insurance. The company has reported a net profit of Rs 513 crore, which is 45% more than the previous year. Its underwriting losses have also shrunk to Rs 18 crore from Rs 88 crore.

Back

Health Insurance

Shoddy service mars utility of social health security programme for workers – Hindustan Times – 8th June 2018

The employees' state insurance (ESI) scheme, a vital social health security programme for workers, has been grappling with inefficiencies and shoddy services for years, data reviewed by Hindustan Times shows, despite a package of so-called second-generation reforms dubbed "ESIC 2.0" launched by Prime Minister Narendra Modi in 2015.

The scheme covering roughly 42% of the organised-sector employment is administered by the Employees' State Insurance Corporation (ESIC), set up under an act of Parliament in 1948. It was launched from Kanpur in 1952 and counts India's first prime minister Jawaharlal Nehru as its first insured person.

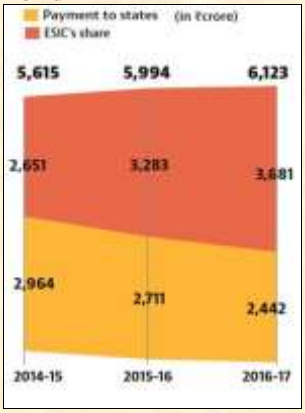
In a country that lacks universalised social security, ESIC is critical for low-wage workers. The ESI law applies to factories or business units employing 10 or more people and employees with monthly salaries of up to Rs21,000 are eligible to be covered.

A deep-seated problem of the scheme is that its "revenue to social spending ratio" has been consistently high, resulting in huge surpluses from premiums. That means collections are consistently and significantly higher than its level of expenditure on social services, particularly healthcare.

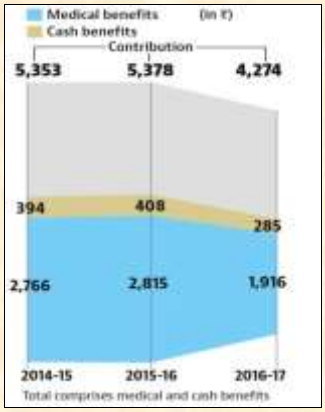
Currently 32 million insured people, along with their families, are entitled to medical care on a network of 152 hospitals and 1,467 dispensaries. They also get cash benefits for wage losses due to sickness, disability or retrenchment.

All about social security
ESIC needs to improve its per capita spending and lower its surpluses, experts say

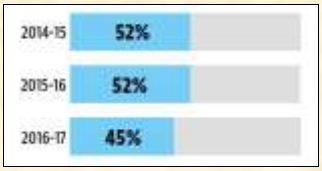
OVERALL MEDICAL EXPENDITURE: RISING

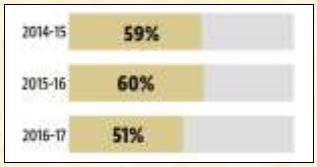


SPENDING PER PERSON: FALLING



BENEFITS VERSUS PREMIUMS





An audit of ESIC by the comptroller and auditor general (CAG) had flagged the lower uptake by beneficiaries as a key issue in 2014. "Performance audit disclosed that ESIC was spending less on services to be provided to its insured persons and its collections were more, with the result that its accumulated surplus was consistently increasing," the CAG audit report stated.

The situation hasn't changed much. Figures reviewed by Hindustan Times show a nearly 50% jump in enrolment has increased ESIC's total allotted expenditure from Rs5,615 crore in 2014-15 to Rs6,124.20 crore in 2016-17.

Yet, per capita spending on medical benefits — or expenditure incurred per individual — fell from Rs2,815 in 2015-16 to Rs1,916 in 2016-17. This means, even though more people are getting covered, fewer people have been able to utilise its services.

While data on ESIC is limited, there seems to be a "very low utilisation rate when compared with the National Sample Survey Office (NSSO) morbidity surveys for the general population", according to Ravi Duggal, a public health expert.

In an analysis published in the EPW journal, he showed that while the annual incidence for hospitalisation for the general population was 26 per 1,000 people, according to NSSO data, the rate of hospitalisation under the ESI scheme was just 6.8 per 1,000 people.

Employees contribute 1.75% of their wages towards premiums, while the employers' share is 4.75%. ESIC funds seven-eighth of the scheme's total expenditure, while state governments bear one-eighth of the costs. In simple terms, if the total expenditure is, let's say, Rs200, then ESIC pays Rs175 and states pay Rs25.

The percentage of medical benefits availed to contribution has either remained stagnant or dipped. It was 52% in both 2014-15 and 2015-16 and then fell to 45% in 2016-17. This too points to lower spending on medical services.

ESIC's share of combined medical and cash benefits to premiums was better at 51% in 2016, meaning it was quicker on disbursing cash entitlements. Even so, this was a fall from 60% in the previous year. "The problem of deficient services is more in the northern and eastern states, such as Uttar Pradesh and Bihar," an official requesting anonymity said.

"Our current surpluses are in the range of Rs3,500 to Rs4,000 crore. One problem is a 30-40% shortage of doctors and medical staff," said Raj Kumar, director-general of ESIC. Another pointer of inefficiency is ESIC's growing outstanding amounts pending with employers, which increased 5% from Rs2,249 crore in 2015-16 to Rs2,362 crore in 2016-17.

Of this, Rs1,263 crore has been declared non-recoverable due to disputes or factory liquidation, according to a Lok Sabha reply.

"The basic fault lies in the very design of the scheme. While ESIC collects premiums, the medical services are delivered through state health departments. Letters have been regularly written to state health departments but hiccups remain," said Rama Kant Bharadwaj, the vice president of Laghu Udyog Bharati, a small enterprise consortium. ESIC's second-generation reforms are being fine-tuned to strengthen medical services, the official

cited above said. ESIC is on course to draft in 3,000 private doctors' clinics, but that is just a fraction of the shortfall.

Source

Under its Vision 2020, it is setting up a string of hospitals, including a super-specialty hospital in Bhubaneswar and a 100-bed unit in Raigarh, Chhattisgarh. A major plan is to set up a network of dispensaries called modified employers' utilisation dispensary in which employers will have a stake.

Back

Ayushman Bharat to be rolled out in alliance with state health plans - The Indian Express – 7th June 2018

It is going to be the NDA health flagship in an election year but the credits for the National Health Protection Mission (NHPM) will have to be shared with the states.

With states, especially those ruled by non-BJP parties having made it clear that there is no way they would give up their own brands of health programmes, Ayushman Bharat, which is the umbrella programme including NHPM and a preventive healthcare component, will be rolled out as an "alliance" with the state health programmes. So in Telangana, Ayushman Bharat will be in alliance with Aarogyashri, in Tamil Nadu, it will be in alliance with the Chief Minister's Comprehensive Health Insurance Scheme and in Maharashtra it will be in alliance with the Mahatma Jyotiba Phule Jan Arogya Yojana.

The first meeting of Ayushman Bharat-National Health Protection Mission Council (AB-NHPMC) that will give policy directions and foster coordination between Centre and States will happen in Delhi on June 14. Chaired by Health minister J P Nadda, the council will be the federal forum for states to voice concerns. The Union Health Ministry is in the process of sending out invites to state health ministers to attend the first meeting.

Announced in the Budget this year, NHPM (since referred to as Ayushman Bharat-NHPM) aims to provide an annual health cover of Rs 5 lakh to 10.74 crore families. Under the preventive health component of Ayushman Bharat, 1,53,000 health and wellness centres will be set up across the country. Beneficiaries for AB-NHPM will be identified on the basis of deprivation and occupational criteria as per Socio Economic and Caste Census 2011 data.

"The issue of co-branding has already been decided so Ayushman Bharat will be in alliance with Arogyashri in Telangana or Swasthyasathi in West Bengal and so on. The memorandum of understanding has been signed with 15 states and this has been built into the document," said a senior official in Ayushman Bharat setup.

All the state health schemes will continue to run. This means that in states where the existing list of beneficiaries is larger than the beneficiary list as per SECC data, while the Centre will pay 60 per cent of the premium for beneficiaries listed as per SECC data, the states would be free to pay the premium for the others from their own resources.

States would need to have their own State Health Agency to implement the scheme. They have the option to use an existing Trust / Society / Not for Profit Company/ State Nodal Agency or set up a new one. The total expenditure on the programme will depend on actual market-determined premium paid in States or UTs where AB-NHPM will be implemented through insurance companies. In States or UTs where the scheme will be implemented through a trust or society, the central share of funding will be provided based on actual expenditure or premium ceiling, whichever is lower.

Source

Back

Modicare rates may rise; states to get sops - The Economic Times – 6th June 2018

Prices of some procedures under the proposed government-run Ayushman Bharat National Health Protection Scheme may go up in some states. In a bid to bring more states on board, the Centre has allowed them to increase rates of procedures to match their existing schemes.

Sources said some price revisions are also likely to get corporate hospitals under the scheme, which have raised concerns against the cap of charges being too low. Earlier, the government had allowed states a leeway to increase prices by up to 10 per cent only.

"We have given directions that under the scheme, states can retain their existing package rates, even if they are higher than the prescribed 10% flexibility slab," NHPS chief executive Indu Bhushan told TOI.

States like Punjab, West Bengal, Chhattisgarh and Delhi had opposed the scheme primarily on grounds that some of the rates are not in line with those in their existing schemes. A major concern was related to the financial contribution of the state to NHPS which says the Centre will share 60 per cent of the cost. The states are afraid that they may have to contribute the excess amount of premium over and above the national ceiling limit fixed by the Centre.

According to sources, while the Centre has now in-principle also agreed to share the excess premium, states which manage to fix the premium lower than the national ceiling will get an incentive. Private hospitals had also raised concerns that they may not be able to provide quality care at rates fixed by the Centre.

Bhushan said though the rates are reasonable and at par with the Central Government Health Scheme (CGHS) if incentives are taken into account, the government is open to revision if there is a strong basis in any particular case.

Dinesh Arora, deputy chief executive of Ayushman Bharat, said it may not be fair to compare the NHPS rates with that of CGHS, which caters to merely 20-25 lakh government employees and pensioners. "Through NHPS we are targeting 50 crore beneficiaries. There has to be a strategic buying by the government if the volumes are going up on such scale," Arora said.

The health insurance scheme, popularly known as Modicare, aims to cover nearly 50 crore beneficiaries from over 10.74 crore "deprived" families as per socio-economic and caste census (SECC) data with an annual health cover of Rs 5 lakh per family per year.

Officials emphasised the government has to streamline the mechanism for timely payment under the scheme, which has been a major concern for private hospitals mainly in case of CGHS.

Under NHPS, the government will release payments to the insurance company under three tranches and has fixed timelines for the same. In case of any deviation, the insurance firm or the hospital can even lodge a complaint with the State Health Agency. In case of delay, the payment will be calculated along with an interest of 1 per cent per week.

Source

Back

How much health insurance cover should you buy? – Mint – 5th June 2018

We get a lot of reader queries asking for the right amount of health insurance cover to buy and the most efficient way to buy it. We asked the experts on how much health insurance cover is necessary and the most efficient way to buy it.

Priya Sunder, director, PeakAlpha Investment Services Pvt Ltd.
When you buy health insurance, remember to buy for the future. If a heart surgery cost Rs5 lakh today, it may cost Rs80 lakh 20 years later. The lowest cover you must have is Rs20 lakh, going all the way to a crore. Look for policies that increase your insurance cover every claim free year. Avoid including elderly members in a floater cover. Consider a top up cover with a deductible to enhance your existing insurance. Such covers are cheaper than basic plans since they kick in only after a threshold has been crossed. Buy medical insurance when you are young and healthy and don't depend on your company's group health insurance.

Mahavir Chopra, director-health, life and strategic initiatives, Coverfox.com
With advancement of medical science, people are more likely to suffer and survive a lifestyle disease that will result in medical treatment. Looking at the healthcare inflation coupled with the lifestyle disease epidemic across cities and towns, a future proof health insurance cover for a young family living in an urban area should be a floater cover of Rs10 Lakhs, supplemented with the maximum top-up available, taking the cover to around Rs20-25 Lakhs. Major treatments that today cost an average of Rs5-6 Lakhs and at a 10% inflation will be billed at around Rs10 Lakh in 8 years and Rs20 Lakh in 15 years, that is when you are most likely to need a medical cover. For senior citizens an individual Rs5 Lakh cover with a super top-up cover of Rs5 Lakh should be adequate.

Nayan Shah, managing director, Paramount Health Group
For a middle class family, minimum sum assured of Rs5 lakh is necessary. One can opt for a floater policy and if the parents are included the sum assured can be Rs7.5 lakh. Over and above this a 'top-up' plan can be bought that kicks off after the basic sum assured is utilized. One can also look at a critical illness insurance

policy that pays the insured a lump sum irrespective of treatment cost. In Urban areas and for those who want to get treated in the higher class of admissions like a single room or deluxe room, the treatment cost can high and they should consider an overall coverage of Rs10 lakh for the entire family in a floater policy. They can go up to Rs15 lakh to Rs20 lakh through higher top-ups.

Antony Jacob, chief executive officer, Apollo Munich Health Insurance Co. Ltd

Before finalizing a policy, one should take cognizance of factors such as current health status, life-stage, city of residence, medical history, nature of job, and the extent of coverage an individual can afford. One should be mindful that premium comparison is not the right evaluation parameter while choosing an insurance policy. It is also important to choose the right insurer. It is prudent to take into account the claim settlement ratio. Cashless and reimbursement turnaround times are a reasonable indicator of how fast the processing of claims is managed by an insurer. For a family of two adults and two children living in a metro, a health insurance plan offering features like restore and multiplier with Rs10 lakh sum insured should be adequate.

Source

Back

Rajasthan Scheme: Insurer de-empanels 66 hospitals, government overrules it - Financial Express – 4th June 2018

New India Assurance Company (NIAC), the insurer in Rajasthan's Bhamashah health insurance scheme, de-empanelled 66 hospitals it suspected of making fraudulent claims, but within a few hours of this, the state government overruled it. In a mail to NIAC's branch head in Jaipur, the joint CEO of the Rajasthan State Health Assurance Agency (RSHAA) said the de-empanelment was "completely unilateral, arbitrary, mala fide and in clear violation of the provisions of the … agreement" between NIAC and the government.

NIAC's actions follow spiraling of insurance claims, from Rs 1.6 crore per day in December 2017 when the second phase of the scheme began, to Rs 3.7 crore in May 2018 (see graphic). Over this period, NIAC has been regularly rejecting claims from those hospitals where it felt the claims were fraudulent.

When the scheme was first begun in 2015, the premium was Rs 370 per family, but due to very high claims, NIAC raised the premium to Rs 1,263 for the second phase in 2017 — from 90% in 2015-16, the claims ratios rose to a staggering 176% in 2016-17 under the first phase of the scheme.

In a reply to this newspaper, the managing director of Rajasthan's National Rural Health Mission confirmed the de-empanelment and its cancellation, saying "the insurance company did not give any opportunity of hearing to these hospitals" and added that, after its intervention, NIAC is hearing the hospital's views.

The dispute stems from the fact that while the Rajasthan government feels the "clauses related to de-empanelment can be invoked by none other than RSHAA" — to quote from the RSHAA mail cancelling NIAC's de-empanelment — the insurance company seems to be relying on Clause 1.25.10 of the agreement that says "De-empanelment is a separate clause and Insurer may initiate the process of de-empanelment irrespective of penalty clause for the hospitals".

While cancelling the de-empanelment, the Rajasthan government has said the hospitals shall continue to work as before and till it is satisfied there is a fraud, "all claims submitted by the hospitals shall be honored and shall NOT be rejected on this ground".

As for the insurance company's interpretation of its contract, the RSHAA mail terms it "mala-fide misinterpretation of the clauses numbered 1.25.9 and 1.25.10 of (agreement) aimed at bringing down the number and amount of claims to wrongly benefit the insurance company".

Source

Back

Private cord blood banks playing on parents' fears: Doctors' body – The Times of India – 4th June 2018

Paying huge sums of money to bank your child's cord blood in a private cord blood bank is of limited use and the government ought to be investing more in public cord blood banks. This was stated by the Indian Academy of Paediatrics (IAP), the largest association of the profession, in a consensus statement. The statement also criticised the private cord banking industry for spreading myths and "using propaganda and exploiting people purely for a profitable business".

"Parents' sense of obligation towards their own children is exploited in this field. Private cord blood banking has been projected as a panacea for a long list of medical conditions in future," noted the IAP, pointing out that in reality the use of cord blood for the child would be very limited. It went on to add that promotional advertisements by private cord blood banks were often misleading, projecting private cord blood banking as "a form of biological insurance".

"Regulation and quality control of cord blood banks are absent and doesn't seem to be a priority for the government. There is not enough being done to promote public cord blood banks," said Dr Anupam Sachdeva, former IAP president and one of the authors of the consensus statement.

According to the American Society for Blood and Marrow Transplantation, the chance of a baby benefitting from its own cord blood is 0.04% to 0.0005%. One's own cord blood cells cannot be used to cure genetic disorders as the cord blood cells would have the same mutation, pointed out the IAP, adding that though one's own cord blood cells could be useful in treating high risk solid tumours, in such cases, stem cells could be readily harvested from the patient's peripheral blood or bone marrow and this would give the same results as using stem cells from cord blood.

A public cord blood bank, in contrast, would be able to pool cord blood from various donors with differing genetic make-up and hence be useful in treating several conditions. Also, like a blood bank, the donor would not have to pay.

The consensus statement, followed by review of scientific literature on the subject, was published in the latest issue of the IAP journal, Indian Paediatrics. The IAP expressed concern over the finding of a survey among doctors in a tertiary care hospital that almost 60% of the doctors were unaware about conditions that could be treated with cord blood cell transplantation. In fact, 90% of the doctors believed that umbilical cord blood from a child could be used to treat thalassemia in the same child, which is incorrect, noted the IAP statement.

Source

The private cord blood banking industry is estimated to be worth Rs 300 crore in India. It costs anything between Rs 50,000 to Rs 1 lakh to get a baby's cord blood stored for about 20 years.

Back

Here's a back-up plan if you can't get health insurance - The Economic Times – 4th June 2018

Health insurance policies can get rejected due to a host of reasons, including age, lifestyle diseases, poor health and so on, but some applications get turned down despite the proposer's youth and healthy lifestyle. Flummoxed?

Take a look at conditions that can lead to denial of health cover.

Organ donors

An individual who has donated her kidney is unlikely to be eligible for a health cover. "This, despite the fact that the donor can perform all routine activities without any hurdles," says Lalitha Raghuram, country director, Mohan Foundation, an NGO involved in promoting organ donation. Insurers, however, view the condition differently. "Such cases, except liver transplants, are treated as an impaired health condition and hence cover cannot be granted," says Nikhil Apte, Chief Product Officer, Product Factory (health insurance), Royal Sundaram General Insurance. Liver transplant is an exception as unlike other organs, it can regain its original size and capacity.

Cardiac history

Past ailments can haunt you even if you are completely cured. Financial planner Bhakti Rasal cites a case where her 42-year-old client's application for health cover was rejected because he had undergone a surgery to rectify atrial septal defect when he was 13. "The surgical closure of the hole in the heart was done 30 years ago. The patient, in such cases, enjoys a normal life and usually never suffers any illness because of this ailment. In this case, he is a sportsperson. Yet, the cover was denied by two private health insurers after submission of past medical records," she explains.

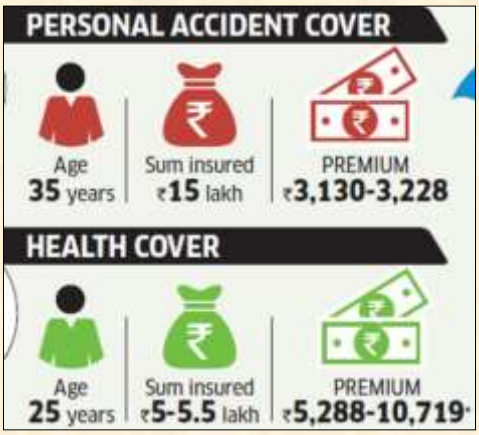
Cancer survivors

The chances of surviving cancer have grown brighter over the years. However, even those who are cured and have crossed the five-year survival threshold cannot buy a fresh health cover.

Clearly, insurance companies are not willing to extend coverage in case where the risk is perceived to be high. "Most of these will get rejected under retail plans as it is believed that they compromise the immunity and the normal functioning of the human body and that the chances of such persons falling ill or contracting some aliments are higher," says Jayesh Gadekar, Head, Health and Benefits, Innovative Solutions, Global Insurance Brokers. Such individuals, therefore, will have to look out for themselves and frame a back-up plan to cushion the impact of rising healthcare inflation.

Here's how you can mitigate the risks of not being insured.

Start early



The key to eliminating the scope for denial of cover is to buy one early. "Even if there is a situation in future where you have to, say, donate an organ, you will be covered as policies come with lifelong renewal clause," says Apte.

Secure your health as early as possible

Lifelong renewal clauses will ensure future setbacks don't mean denial of cover.

Bank on group covers

If your employer provides a corporate health policy, you have little to be worried about as pre-existing diseases are usually taken care of. Sign up for such policies even it means funding part of, or even the entire, premium. "Being a part of a group insurance program is the best alternative as of now. It is also advisable to go for a top-up plan offered by corporates," says Gadekar.

Under such plans, employees are offered voluntary top-ups to enhance the base group cover. Employees are usually allowed to continue with such add-ons even after they quit their organisations. Moreover, you could also avail the option to port from your group policy to the same insurer's retail plan at the time of switching jobs or retirement to enjoy continuity benefits. This can be beneficial for cancer survivors, those suffering from lifestyle diseases or other ailments. However, approving such applications and computing premiums is at the insurer's discretion.

Buy personal accident policy

A health insurance policy covers hospitalisation expenses, including for accidentrelated treatments. While a personal accident policy cannot compensate for lack of health cover, it can foot bills for accidents and consequent disabilities. "In this case, the applicant's income, and not health background, comes into the picture. You can opt for a personal accident plan to safeguard against accident risks," says Rasal.

Build a healthcare corpus

This is a measure all individuals ought to take, but it is simply indispensable for those with adverse health conditions. Rasal, for instance, got her client to create a special needs medical kitty comprising liquid and short-term debt funds.

Build a financial shield

Create a corpus for medical needs

Instrument	Tenure	Returns
Liquid funds	1 year	6.74%*
Short-term bond funds	1 year	5.39%*
Fixed deposits	1 year	6.65-6.85%

She took into account his age, inflation and occupation for estimating the kitty, while a floater plan was purchased to cover the rest of the family. "When you create a corpus for this purpose, remember that returns are not important. What is critical is that the money should be accessible at short notice," she adds. Depending on your requirements, allocate a part of your income towards these funds every month. You can also look at a sweep-in account where excess funds are automatically transferred into a fixed

Source

deposit and fetch higher returns of 7-8%. "Ensure you have a debit card with adequate cash withdrawal limit. Many people remain unaware of their debit card's daily cash withdrawal limit," she says. Having your own emergency fund to dip into without waiting for approvals from health insurers or third-party administrators is key to ensuring peace of mind.

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Buying insurance? Tick these life, health cover boxes first – Mint – 4th June 2018

You may not be as fit in your 50s as you were in your 20s. That's a fact of life: as you grow older, your body shows signs of wear and tear and you need more medical care than before, worse lifestyle choices make you susceptible to life altering ailments that can also cost a bomb.

Research shows that heart ailments and cancer account for over half of casualties among Indians. In fact, India has the highest rate of cardiac arrests in the world and every 13th new cancer patient is from India, research suggests. If the facts disturb you and you don't have adequate life and health insurance plan, you should indeed be worried.

A health insurance policy pays for your hospital bills and life insurance provides timely financial support to your loved ones after you die. Both are important covers to have and we tell you who needs these policies, how much and how often one needs to review the cover.

LIFE COVER

Who needs it and when?

Not everyone needs life insurance. Children and young adults who are not working and retired individuals come under this category and that's because they don't have anyone depending on them financially. If you are not working, you are not providing for anyone. Similarly in your sunset years, your children are working and you have amassed enough assets to fall back on.

It's the sandwich generation—the working class that provides for children and often older parents—that needs life insurance; in fact buying life insurance needs to be a priority for this generation. Mint Money recommends buying a term insurance cover, but how much should you buy? Life insurance plans are typically level term policies, which means you pay the same premium for life.

How much cover do you need?

According to KS Gopalakrishnan, CEO, RGA (Canada-based reinsurance firm), India, the younger you are, the higher cover you need. "The thumb rule says 10 times the annual income, but the actual need could be between 10 and 25 times," said Gopalakrishnan.

"Younger individuals don't have enough assets to fall back on. They have more number of working years ahead and liabilities only increase in terms of expanding family and big ticket loans. A higher multiple therefore works, as they can get it at a cheaper cost and don't have to keep reviewing and buying more insurance policies," he added.

A cover of 10-25 times your salary may look huge to you now, but if you factor in the time value of money, you will realise it won't be all that big many years down the line. "If you are a salaried individual, insurers can give a cover up to 20 times your annual income. So, opt for a higher cover early on. Then you need not review your life cover often. A relook is needed when you have a baby or once in 10 years,"said Kapil Mehta, co-founder, SecureNow.in.

"For a large loan you could take a separate term plan. But other than this, you don't need multiple policies. Also, given that premium for term plans have fallen in recent times, it may make sense to review your insurance and buy a new plan and then lapse your older, more expensive plan," added Mehta.

HEALTH COVER

Why do you need it?

Everyone needs health insurance and that's because the cost of medical treatment is high. "While ailments may not be much of a concern for young people, accidents can still happen. They need health insurance to financially protect themselves against hospitalization due to accidents or even infection," said Jyoti Punja, chief customer officer, Cigna TTK Health Insurance Co. Ltd.

Such cases of hospitalization can work up a neat bill. For instance, dislocation, sprain and strain of joints and ligaments that needs surgical intervention or fracture of the leg needing surgery can cost up to ₹4 lakh in metro cities and up to Rs 2 lakh in non-metros.

Which plan should you buy?

If you are single and working, you can start with an individual policy. Once you get married, increase the cover by buying a floater policy. "A floater policy works best for a family in the same age group. But if there is a large age gap between the spouses or if parents need health insurance as well or if a family member suffers from ailments like diabetes, then individual insurances for these members may be better"added Mehta. Infants and young children can be added to a floater policy.

How much cover do you need?

A health insurance policy is a must but it's equally important to understand how much you need to buy. It's also important to get this right because as you grow older you may contract ailments and then it's an uphill task to get insured. It's always a good idea to have your own health policy but how much will depend on various factors.

"You need to first understand the type of hospitals you would visit. Today, in a corporate hospital in a metro, treatment for a heart attack can cost upwards of ₹10 lakh. That's the minimum you need. This amount will increase over time so you need to review your health insurance sum assured every 3-5 years," added Mehta.

For senior citizens, individual plans may work best.

How to increase your cover?

You can increase your health insurance by buying a top-up plan that comes with a deductible. It's important to have a decent base cover because that way a top-up plan can be very cost effective.

Other than this, you can also buy a critical illness policy that pays a lump sum on diagnosis of a critical illness such as cancer. This policy works to supplement your income. But remember a health policy doesn't pay for the entire cost of hospitalisation, so your emergency fund needs to have a corpus for medical emergencies. Money management is important, but it's not limited to savings and investments alone, buying the right kind of insurance is an important step to that end.

Source

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Bolster your health insurance with top-ups - The Hindu Business Line – 2nd June 2018

You may have taken a health cover early on in your career. But is the insurance, which you took a while ago, enough to cover healthcare inflation? According to a recent report from advisory firm Willis Tower Watson, medical inflation in India has been over 10 per cent for the last few years and is expected to be 11.3 per cent in 2018.

Insurers expect healthcare costs to escalate by around 15 per cent every year. You will need an individual or a family floater policy for at least Rs 10-15 lakh. You can always take a second plan, but that may entail paying a large premium.

Therefore, a top-up or a super top-up policy can be taken at a fraction of the cost you would incur for a regular policy.

Increasing your health insurance cover by taking a top-up policy is cost-effective. Companies such as Apollo Munich, ICICI Lombard, United India Insurance, HDFC ERGO and Bajaj Allianz offer such policies. A basic health cover of Rs 5 lakh would cost a 35-year-old Rs 8,500- Rs 13,500 a year, for covering himself, his wife and their child.

On the other hand, a top-up policy with a sum assured of Rs 10 lakh and a deductible of Rs 2-3 lakh would cost only Rs 4,300-6,330 (in addition to the premium for the basic cover).

There are some conditions attached, though. All top-ups are taken with a 'threshold' level or 'deductible'. Let us assume you have a basic health cover for Rs 3 lakh and then choose to take a top-up cover for Rs 10 lakh. Payments become due from the top-up policy only after you cross the threshold level.

In the above example, the threshold level of the basic policy is Rs 3 lakh. The top-up cover would come into effect only after the Rs 3 lakh in the threshold level is exhausted. Suppose you make a claim of Rs 7 lakh, the base policy would pay you up to Rs 3 lakh and the top-up would pay Rs 4 lakh. Suppose you have a regular policy of Rs 5 lakh and a top-up for Rs 10 lakh with Rs 5 lakh as the deductible. If you run up two bills of Rs 3 lakh each, your top-up policy will not pay you anything, as the deductible level is not breached. So in this case, you will have to pay Rs 1 lakh from your own resources.

Super top-up option

This shortcoming of top-ups is overcome by super top-up policies. HDFC ERGO, Apollo Munich and United India Insurance are among the few that offer this cover. Now, assume that you have a basic cover for Rs 3 lakh, and take a super top-up for Rs 12 lakh with Rs 3 lakh as deductible.

If you have a claim for Rs 4 lakh, and later in the year run up another medical bill of Rs 4 lakh, the super top-up would fill in with Rs 1 lakh (Rs 3 lakh from basic cover) for the first time and the entire Rs 4 lakh during the second time.

Super top-up policies also offer large covers in excess of Rs 15 lakh. The premium for a Rs 20-lakh sum assured policy from HDFC ERGO with Rs 5 lakh as deductible is just Rs 3,850 for a family floater (two adults and a child), if the eldest member is 35 years old.

Other parameters

Top-up policies offer cashless settlement at network hospitals if intimation is given 48 hours before any planned treatment or within 24 hours after admitting in case of an emergency. Else, the reimbursement route is available. As with a regular policy, there would be a minimum waiting period (two-three years), exclusion of treatment in case of some ailments and individual limits for specific diseases.

In case your basic policy and the top-up cover are from two different companies, informing the two insurers and getting the claim settled may be cumbersome. But if you can choose a network hospital common to both insurers, the process might be simpler. There are no claim bonuses available on top-up plans. The entry age allowed by insurers is high — 65-80 years. So, you can consider adding your parents in your top-up cover even if you haven't done it in your regular policy. You can take a top-up policy even if you don't have a regular health cover.

Source

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Crop Insurance

Nitish dumps PM Fasal Bima Yojana – The Pioneer – 7th June 2018

Bihar Chief Minister Nitish Kumar has dumped Prime Minister Narendra Modi's flagship programme Pradhan Mantri Fasal Bima Yojana (PMFBY) on the ground that it was helping insurance companies more than farmers. In its place, the Nitish Government on Tuesday launched its own Bihar Rajya Fasal Sahayata Yojana (BRFSY) to provide relief to farmers.

The scheme will be for all types of farmers — those who have their own farms, as well as those who work on others' fields. More than 90 per cent farmers in the State have less than two hectares of land.

Interestingly, the farmers in Rajasthan have approached the Information Commission asking about the promised benefits of the PMFBY.

The BRFSY will provide financial help to farmers, shield them against nature's vagaries, provide continuity of income in adverse situations and make agriculture a profitable livelihood. The move has come just a day before the talks between the NDA constituents in Bihar, where the issue of seat-sharing for 2019 Lok Sabha polls is expected to be high on agenda. Unlike the PMFBY, where the farmers have also to pay a part of the premium, they will not have to pay anything from their pocket under this scheme.

The farmers will be able to avail the benefits if they incur crop damage due to natural calamities. Under the new scheme, farmers will be registered online without any charge, no fee will be taken from them and benefits will be directly transferred to their bank accounts. It will be implemented from the upcoming Kharif season.

The scheme has been conceptualised by senior IAS officer Amrit Lal Meena. It will be implemented by the Cooperative Department of Bihar. The Government has allocated Rs 300 crore in the first year.Officials said that Bihar had been wary of the PMFBY ever since it was launched in 2016. The State has been at loggerheads with the Centre over crop insurance for the last couple of years, especially when Nitish was a part of the Grand Alliance.

Clarifying his stand, Nitish said that the Centre and the State were depositing premium to the insurance companies and the farmers too were supposed to pay 2 per cent of premium but they were getting little relief. "For Kharif and Rabi seasons insurance companies were deposited Rs 800 crore (Rs 400 crore each from the Centre and the State) but the farmers got relief worth Rs 150 crore, so we decided to bring our crop assistance scheme," the CM said.

The BJP claimed there was no clash of interest and no differences. Bihar Agriculture Minister Prem Kumar, who is from the BJP, said, "There is no difference between the Central and the State schemes. Whatever decision the PM took has been further reformed in the State scheme.

This is a good initiative and there is no politics. This scheme will benefit the NDA Governments at the Centre and in Bihar." Kumar said this was a collective decision and all the NDA allies supported it. The number of farmers insured during both the Kharif and Rabi seasons has gone down by 14 per cent this year, the area under crop insurance scheme has come down to 24 per cent of gross cropped area (GCA) in 2017-18 from 30 per cent in 2016-17.

"Over 1.20 crore farmers benefited from the crop insurance scheme during the Kharif season last year and the Rabi season in 2016-17 as compared to 1.62 crore in 2013-14. In 2016-17, over 5.73 crore farmers insured their crop while 3.33 crore farmers in 2013-14," the Agriculture Ministry had said in a reply to Parliament during the Budget Session.

The crop insurance scheme is the Narendra Modi Government's flagship scheme, launched with much fanfare two years ago to protect farmers. Under the scheme, farmers have to pay just two per cent of the total premium in case of the Kharif crop, 1.5 per cent for Rabi and five per cent for horticulture. The remaining premium is equally shared by the Centre and the States.

In 2017-18, the area insured under the PMFBY was 47.5 million hectares, which translates into 24 per cent of the GCA of 198.4 million hectares. As per the Government's targets, the coverage in 2017-18 should have increased to 40 per cent but has actually reduced to 24 per cent.

Source

The crop insurance scheme has also witnessed a 14 per cent drop in the number of farmers insured to 47.9 million in 2017-18 from 55.3 million in 2016-17. Binod Pandey, a farmer leader, told The Pioneer that farmers had lost interest as the compensation was either denied or delayed.

Back

33 lakh farmers yet to get 1,600 crore crop insurance, likely to be cleared in a week – The Times of India – 6th June 2018

Over 33 lakh farmers in the state are waiting to get their crop insurance claims of the previous season. Even as it is the fifth season of Prime Minister Agriculture Insurance Scheme, the claims for last year's cropping season have been delayed by over two months.

In the normal course, the insurance money is expected to be paid by March-April. This year till May end claims to the tune of Rs2,300 crore of 45 lakh farmers had remained unpaid. Chief minister Devendra Fadnavis had convened a meeting of representatives of the insurance companies through which the schemes are offered.

Fadnavis who had expressed displeasure over delay in payment of insurance dues had directed the companies to clear the pendency by June 7. After this dues to the tune of Rs560 crore for nearly 11.60 lakh farmers have been paid. Now over Rs1,600 crore remain for 33 lakh others.

An official in the state's agriculture department who is handling the issue said, insurance companies are being pushed and the dues are expected to be cleared in the coming week. The official accepted that the money should have been paid by April at the most. "The objective behind ensuring early payment is that the farmer who has suffered losses, has money in hand to purchase inputs for next season in time," the sources said.

Sources in the department said the delay was due to a mix of reasons. This year an online system of direct payment into farmers' accounts was put in place. The insurance companies faced hassles in the implementation. Apart from it some of the companies which were roped in for selling the polices too faltered processing the claims leading the delays.

The insurance is linked with the crop loans and majority of the advances are through district central cooperative banks (DCCBs). The DCCBs have a four digit account number as compared to a 16 digit number of other accounts where online payment can be made. It took time for the insurance companies to validate such accounts which in turn delayed the process, said a senior official.

Earlier it also was seen that often farmers did not immediately get the amount especially where the accounts were with DCCBs. The cooperatives which often face liquidity crisis withheld the insurance money to meet the immediate liabilities. This is also one of the reasons for having a system of direct online payment, an official said.

Source

Back

R'sthan Farmers Seek Details of Insurance Payout - The Economic Times – 6th June 2018

Rajasthan farmer associations have knocked at the Information Commission's door, asking about the promised benefits of Prime Minister Fasal Bima Yojana (PMFBY). Last month, nine organisations complained to the CIC, saying they are not being provided with information by insurance companies and the promised benefits have not reached them.

The Centre's flagship crop insurance scheme was seen as the government's bold step to revamp the crop insurance after successive droughts in 2014 and 2015.In their complaint to the IC, the petitioners have said that the scheme was supposed to help farmers during unforeseen calamities, by "ensuring proper assessment of damagesandsettlementof claims." Now, the companies don't even show us the inspection records. They tell us we will get nothing if wedon'tinformthemin24hoursof damage," a petitioner said.

Specifying the names of United India Insurance, the complainants have said that they have been told that as per the guidelines issued in relation to the PMFBY, payment of insurance claim could only be madeafterreceivingthegrantfrom thegovernmentandthattheassessment of claim based on survey report and other material facts was under consideration and hence "the information sought could not beprovidedatthatstage."TheIC,in an order by CIC Bimal Julka last week, has asked the companies to put out all information free of cost on their website within two weeks.

Source

Back

Insurance Cases

Not repaying mediclaim costs insurance firm dear – The Times of India – 4th June 2018

The district consumer disputes redressal forum directed Oriental Insurance Company Ltd. in Sector 17, Chandigarh to pay Rs 30,000 for failing to repay the treatment claim to the complainant after her husband's death, as she was the nominee. They were also told to pay Rs 80,000 along with 9% interest from February 28, 2014 till realization. The complainant, Promilla Bhalla (68) of Panchkula stated in her complaint that her husband Baldev Bhalla had purchased an insurance policy from Oriental Insurance Company in 2013. She was the nominee in the programme.

Promilla is a regular client of the company and had obtained successive policies from the insurance firm. She added that her husband suffered some ailment and was admitted in Indus hospital, Mohali and died due to cardiac arrest on November 29, 2013.

After some time, Promilla filed for insurance claim on December 11, 2013. During investigation, the complainant was asked to deposit some documents regarding the first diagnosis of chronic kidney disease and treatment of the complainant's husband at Sector 32 hospital, Chandigarh, for the finalization of claim. The claim was however repudiated.

The insurance company contested that the claim of the complainant was closed as the requisite documents were not submitted. Specific details of the hospitals were not given and only sketchy papers, OPD card of November 24, 2013 was submitted which reflected CBC, RFT, LFT and chest X-ray were advised, and her husband was diagnosed with chronic kidney disease. More documents about the kidney disease were sought but the same were not supplied.

The forum after hearing both sides held that the insurance company did not produce any record, that is the form which was filled up by the complainant and her husband. Since the complainant had been buying mediclaim policies for herself and her husband in the past too, there is no concrete material on record to suggest that this present policy was taken just to make a claim when her husband was near the termination of his life.

Source

The forum held that the insurer had happily accepted the premium of Rs 6,830 on September 6, 2013 and the date of death of Baldev Kumar Bhalla was November 29, 2013. Thus, there has been deficiency in service on the part of the insurance company, the firm held.

Back

Pensions

Wage ceiling may be hiked to expand EPS net - The Economic Times – 7th June 2018

After dilly dallying for more than a year, the labour ministry may enhance the wage ceiling from Rs 15,000 to Rs 21,000 to bring more subscribers under the pension net. This could cost the exchequer Rs 2,500 crore annually and an estimated 6 million people will become eligible for minimum pension of Rs 1,000 a month under the government's Employee Pension Scheme.

This is over and above the Rs 4,000 crore the government contributes at the rate of 1.16% for over more than 4 crore EPFO subscribers and is seen as a targeted approach to appease country's increasing workforce ahead of general elections next year. The EPFO had hiked salary threshold from Rs 6,500 to Rs 15,000 in August 2014.

This U-turn comes two month after labour minister Santosh Gangwar said there is no such plan at this point. However, the labour ministry recently asked EPFO to furnish financial implication of the proposal, a senior government official told ET on the condition of anonymity.

This has been a long pending demand of trade unions to expand the coverage of social security net by enhancing the wage limit, the official said, adding "I don't think we will sit on it for long. It's only a matter of time that the government makes an announcement."

The government pays 1.16% of the wages to each subscriber earning less than Rs 15,000 a month towards EPS. Under current rules, it is mandatory for units employing 20 or more people to provide EPF benefits to workers. While employees contribute 12% of the basic pay to EPF, the employer contributes 8.33% of the pay (up to Rs 15,000) towards EPS and 3.67% of the pay to EPF.

Employers also pay 0.5% towards employee deposit linked scheme (EDLI), 0.65% as EPF administrative charges and 0.01% as EDLI handling fee. Though there exists a threshold for mandatory cover, employers and workers can opt for the scheme even if the salary levels are higher.

The government provides a grant of Rs 4,000 crore per annum towards payment of minimum pensions of Rs 1,000 per month. The Central Board of Trustees, the highest decision-making body of EPFO, had approved raising the wage cap for mandatory EPF cover to Rs 25,000 per month for organised-sector workers long ago but the labour ministry decided to raise it to Rs 21,000.

Source

This is primarily because the government could end up saving excessive outgo on funds and this wage ceiling would be in sync with the wage ceiling for subscribers to avail health insurance under the Employee State Insurance Scheme.

Back

Pension schemes need strong sense of purpose – Mint – 4th June 2018

Opinion by - Kulin Patel, head of retirement, South Asia, Willis Towers Watson

India needs to define and review the purpose of the different so-called retirement plans that salaried employees are eligible for, and possibly scrap pension under the Employees' Provident Fund (Employees' Pension Scheme 1995, or EPS95). However, we recently saw the Employees' Provident Fund Organisation (EPFO) embroiled in a matter where salaried employees' EPS95 pension has the potential of increasing significantly. There are several factors and ramifications that need to be considered.

Employers: As on 31 March 2016, there were over 900,000 unique PF codes from establishments registered with the EPFO. Of these about 4,365 unique codes were from about 1,500 establishments with exempt private PF trusts. While, in the context of the current discussion around EPS95, there are no significant additional costs or liabilities that the employer will bear, a lot of communication to the employees to explain a complex issue and additional administrative work around recalculating contributions will be required. Exempt trusts too could be burdened with more record keeping, administrative challenges and investment issues.

Employees: Those who joined the EPFO before September 2014 are potentially the biggest gainers as they could get a guaranteed pension from EPS based on uncapped PF wages (currently limited to Rs15,000 per month). Let's take an employee who joined the EPF at the age of 25 in 1996 with a monthly basic salary of Rs10,000 (and gets reasonable salary increases). His projected eligibility for the maximum monthly pension is Rs7,500 at age of 58 under the capped arrangement of EPS95. However, the pension amount would increase sharply if the cap on salary is removed. Assuming an annual salary hike of 6%, the uncapped monthly EPS95 pension for the same employee increases to about Rs29,000 per month. At 8% per annum salary increase, it would be over Rs50,000 per month (if the employee remains in EPF until age 58).

In exchange for the higher amount, the EPFO would need to calculate retroactive EPS95 contributions on the uncapped salary. Employees who have already taken their PF benefits will need to find a considerable amount of cash to contribute back to the EPFO for these retroactive contributions. Employees still working and in the EPF may not need to pay anything additional. Their retroactive higher contributions will come from a notional "transfer" from their existing main EPF account.

EPFO: With employees gaining so much and employers not impacted, who picks up the cost of the much higher EPS95 pension?

The main point is whether 8.33% contribution to EPS is enough to fund the EPS95 benefit obligation. Based on some simple assumptions and actuarial models, the answer is a definite no.

I have estimated the "cost" of our sample employee electing the EPS95 option, to the EPFO. I have estimated a "present value" of pension payments that EPFO will need to pay, less the value of the notional accumulated EPS95 corpus of the member. If the value of the projected pension payments is more than the projected notional EPS95 corpus, then EPFO pays (and the employee gains). To calculate the pension stream value, I have taken an assumed cost to purchase an annuity. Making suitable assumptions, the net present value (assuming 8.5% per annum) of the shortfalls roughly work out to Rs3.9 lakh, Rs12.5 lakh and Rs28.5 lakh under salary increase assumptions of 6%, 8% and 10% per annum, respectively.

This is the cost to be borne by the system for just one person. The vast range of salaries makes it difficult to extrapolate to the broader membership of EPFO. However, it would be very large due to high earners.

If these huge costs emerge over time, they will either need to be covered by increasing the 8.33% contribution rate or reducing the benefits or even asking employers and employees to pay more than the 12% total EPF contribution or funds from the government. Notably, the existing EPFO contribution of 1.16% of wages contribution for EPS95 will cover that part of the cost too.

While the EPS95 development is no doubt good for employees, it does beg the question: at what cost? We may be going back to a defined benefit regime that goes against the long-term direction that India has implemented for defined contribution pensions.

For National Pension System (NPS), I fear take-up rates in companies in the organised sector may fall substantially. A Willis Towers Watson's India 2017 Retirement Governance survey revealed that 90% of companies still face take-up rates of less than 25% in NPS. For employees, the latest on EPS95 will make NPS unfavourable (through no fault of its own).

Source

We need to assess the impact and determine if long-term costs are well spent on a long-term defined benefit scheme or on incentivizing a defined contribution environment and social security for those who really need it. This should be considered further while the Labour Code on Social Security is also being developed.

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IRDAI Circular

Source

List of Insurance Marketing Firms as on 31.05.2018 is available on IRDAI website.

Source

List of corporate agents registered with the authority as on 31st May 2018 is available on IRDAI website.

Back

Global News

Positive signs of bridging CAT protection gap in Asia – Asia Insurance Review

There are encouraging signs that the natural catastrophe protection gap in Asia can be bridged, owing to factors such as relaxation of market access restriction in the region as well as the power of technology.

Speaking at the 16th Conference on Catastrophe Insurance in Asia in Singapore yesterday, Swiss Re's Head of P&C Underwriting Sharon Ooi listed four promising signs to close the protection gap in the region.

Firstly, the overall liberalisation in (re)insurance regulations in the region has allowed for increased participation in the insurance market.

Secondly, there exists stronger support for data-sharing in various jurisdictions.

Thirdly, regional collaborative efforts are in place that can facilitate higher penetration of insurance; while lastly, the ability to leverage on technology allows for greater efficiency and convenience in terms of distribution, underwriting, policy servicing and claims.

However, Ms Ooi added that insurers would need to canvass the support of governments and regulators to help bridge the protection gap.

Asia saw US$31bn of economic losses due to natural catastrophes in 2017, of which US$26bn were uninsured.

Models facilitate markets

The availability of models is an important aspect in insuring against natural catastophes, and Mr Hemant Nagpal, Director, Model Product Management at RMS spoke of his organisation's efforts to ensure the robustness of its models in the region.

For example in Japan, RMS most recently released a high-definition Japan earthquake and tsunami model, incorporating key research advancements on recent earthquakes to have hit the country. It has also

incorporated a fully probabilistic tsunami model, thus providing a comprehensive view of earthquake risk for Japan.

Making climate change a boardroom issue

Meanwhile, insurers can do even more to make managing climate change a board room issue, said Mr Shitalkumar Khandar, Regional Catastrophe Leader at AIG.

He suggested five key takeaways to make boards more engaged with mitigating climate change. Firstly is the need to articulate the threat of climate change and align it with the long-term success of the business.

Secondly is to illustrate the scope of the issue in terms of possible events and durations and how that may impact on business strategy. Thirdly, it involves the need to uphold best market practices as part of a socially responsible and ethical organisation, while the fourth and fifth points relate to the uncertainties as well as the risk and opportunities of climate change and its impact on business operations.

Day 1 of the conference was chaired by Ms Christine Ziehmann, Vice-President of RMS. The conference ends today. The 16th Conference on Catastrophe Insurance in Asia is organised by *Asia Insurance Review* and sponsored by RMS.

Source

Back

Sri Lanka: More M&A action predicted in insurance sector – Asia Insurance Review

Further consolidation by way of mergers and acquisitions (M&As) is expected in Sri Lanka's insurance market, particularly in the general insurance segment, as the players continue to compete in a crowded market amid tougher operating conditions due to enhanced capital requirements, says Fitch Ratings.

The Insurance Regulatory Commission of Sri Lanka, the country's insurance industry watchdog, in 2014 directed composite insurers to segregate their life and non-life businesses and operate them under separate entities, while increasing the capital required to stay in business.

Both these developments triggered divestitures by some local players of their non-life businesses mostly to large foreign players so that they could focus more on profitable long-term life insurance business.

In its "*Sri Lanka Insurance Dash Board*" for the second half of 2018, Fitch said, "Further industry consolidation is likely, given the competitive nature of the non-life insurance market where some players are incurring underwriting losses.

"In addition, recent regulatory developments including higher capital requirements and split of composites have also hastened consolidation."

Among recent deals, Fairfax Asia bought 78% of the general insurance business of Union Assurance in 2014 and the same company bought all of Asian Alliance General Insurance in 2016. Meanwhile, AIA Insurance sold its general insurance business to Janashakthi Insurance in 2015 before the latter sold its 100% stake in their general insurance business to the local unit of the German insurance giant Allianz in February 2018.

Meanwhile, Fitch Ratings believes the exposure of Sri Lanka's non-life insurers to extreme weather-related events is manageable due to extensive use of reinsurance. However, reinsurers are seen reducing ceding commissions to reflect the increasing risk of catastrophes.

"Sri Lanka has seen a recurrence of extreme weather-related events – back-to-back floods in May 2018 and over the past two years, and a prolonged drought in several parts of the country, which we believe may raise long-term risks for insurers' capital", said the note authored by insurance industry analysts at Fitch, Rishikesh Sivakumar and Jeffrey Liew.

Source

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Thailand: Regulator to broaden insurance distribution avenues – Asia Insurance Review

The Office of the Insurance Commission (OIC) intends to allow financial institutions to sell insurance products via the telesales channel and post offices, aiming to expand insurance penetration in rural provinces.

OIC secretary-general Suthiphon Thaveechaiyagarn said that bank staff are still forbidden to engage in insurance sales outside bank branches, according to a report in *The Bangkok Post*. At present, banks are only permitted to sell life and non-life insurance products at their branches and online.

The OIC's new permission awaits ratification as the related regulation is being drafted. Once the draft is finished, the OIC will forward it to the Office of the Council of State for consideration. The OIC is also undertaking other regulatory revisions including establishing a Centre of Insurtech Thailand (CIT) and enhancing fraud management mechanisms to prepare for disruptive insurance innovations. The CIT is expected to be set up in July.

The insurance regulator is also revising a law to allow the OIC to have direct supervision of insurance intermediaries, a shift from the current regulation that allows the OIC to regulate insurance agents via insurance companies. Insurance agents remain the major distribution network for life business, while brokers are still the major sales channel for non-life insurance.

Source

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Indonesia: Insurers hopeful govt asset insurance scheme can start this year – Asia Insurance Review

The insurance industry in Indonesia expects that an insurance programme covering government assets will be able to start running this year. Insurers have formed a consortium called State Property Insurance (BMN) to undertake the programme.

Mr Yasril Rasyid, a director of Reasuransi Maipark Indonesia, said the government is still reviewing state assets in the country that can be insured, according to a report by *Kontan*. He said that Maipark is assisting the Finance Ministry to draft the implementation guideline, which is likely to be completed this year. The technical guidance will cover the scope of assets to be insured, insurance procurement system, insurance management, claims handling and other details.

On his part, Mr Dadang Sukresna, chairman of the General Insurance Association of Indonesia (AAUI), explained that the association is waiting for the BMN insurance scheme to be finalised. It is still being drafted by the Directorate General of State Assets of the Ministry of Finance and the Financial Services Authority (OJK).

Last month, AAUI had a meeting with the Directorate. It was agreed that the association would prepare a draft BMN policy for All Risk Property Insurance and disaster insurance. Insurance premium rates will also have to be agreed on.

Source

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China: Insurers allowed to invest in long-term rental housing projects – Asia Insurance Review

China's insurers can now invest in long-term rental housing projects, the banking and insurance regulator has announced. The new rules, which took effect on 28 May, broaden investment channels for insurance funds.
Insurers can invest in both equity and debt related to such projects. They can invest directly, through asset management firms, credit investment plans among other methods in long-term rental housing projects, says a notice issued by the CBIRC.

The housing projects must benefit the economy and society and have stable cash flow. Projects should be located in in large and medium-sized cities and areas that see net population inflows, such as Beijing, Shanghai, and the Xiong'an new districtin Hebei Province. All necessary approvals for the project must be in place, including planning, construction, operations and management. If a debt investment plan is used, the borrower must make sure that it has 100% of the funds to repay principal and interest.

For debt investment, cash flow of the entities being invested should cover at least the amount of principle and interest of their debt payable.For equity investment, insurance funds should not use the equity of the target projects as collateral to a third party. Registration of insurance asset investments in long-term home rental projects will be fast-tracked, the statement says.

Source

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Philippines: Bill being drafted to provide for free climate-based crop insurance – Asia Insurance Review

A Bill that will replace the distribution of disaster funds to farmers with free climate-based crop insurance is now in the works.

Senator Cynthia Villar, chairman of the Senate committee on agriculture and food, said that the Senate is already drafting the final version of the Free Index-Based Crop Insurance Bill and is targeting to pass it by year-end.

She said this is the first Bill to consider weather conditions as a trigger for insurance claims. The move aims to strengthen the resilience of small farmers against climate change and extreme weather risks by establishing the regulatory framework and programme for a free weather index-based crop insurance, reports *Manila Bulletin*.

Based on the initial version of the proposed law, the government will tap private insurance companies and will pay them to distribute crop insurance to farmers.

Ms Villar said that money from the country's disaster fund, instead of being distributed to victims of a calamity, will be used instead to pay for the premium for the climate-based crop insurance. The trigger point for insurance payouts would be determined by the Philippine Atmospheric, Geophysical, and Astronomical Services Administration.

Another crop insurance measure is being pushed by lawmaker Arthur Yap in the House of Representatives. The Bill by Mr Yap, a former agriculture secretary, aims to make available index-based insurance coverage. A United Nations report has identified the Philippines as the third most-at-risk from climate change in the world, ranked behind the South Pacific island nations of Vanuatu and Tonga.

Source

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Japan: Non-life results hit by overseas catastrophe losses – Asia Insurance Review

Japan's top four non-life insurers' average combined ratio remained strong but deteriorated to 95% in the financial year ended 31 March 2018 (FY18), affected by weather-related loss events including US hurricanes, says Fitch Ratings.

The combined ratio (excluding the impact of catastrophes) also worsened slightly. This was due to the completion of upward premium revision in the mainstay voluntary automobile business lines, in addition to rising repair costs.

Insurers are projecting their loss ratio – excluding the compulsory auto-business lines and residential earthquake insurance – to remain largely flat, in FY19.

Fire premium rate to be increased

Insurers expect net premium written (NPW) to decline by 0.2% in FY19, based on their aggregate forecasts. Nonetheless, non-life insurers are likely to revise upward the premium of the fire business lines in 2019, given the lower underwriting results.

Overseas M&As

The three non-life groups (Tokio Marine, Sompo and MS&AD) are continuing to look for M&A opportunities, particularly in the developed markets, to offset sluggish domestic growth prospects.

Each group plans to expand the contribution from overseas business to 40%-50% of their respective earnings. However, MS&AD and Sompo suffered losses from their newly acquired overseas subsidiaries.

Fitch sees due diligence, post-merger integration and prudent risk management as important factors for cross-border M&A.

Diversification of risks

The three non-life groups have been diversifying their portfolio into overseas underwriting and life insurance risk, and reducing investment risk and domestic catastrophe risk.

However, investment risk has remained the biggest component of the overall portfolio, despite the continuous reduction of cross-held shares. Fitch feels that Tokio Marine is one step ahead in terms of diversification of risks, based on the groups' disclosures.

Strong capitalisation but exposed to volatility

Non-life insurers' average solvency margin ratio remained high at 765% at 31 March, compared with 756% a year earlier, due to better financial market conditions. Some continued to issue subordinated debt to strengthen capitalisation, while maintaining low financial leverage. The non-life insurers continued to issue catastrophe bonds in 2018, in addition to their reinsurance arrangement to mitigate these risks. Fitch expects non-life insurance groups' capital adequacy to remain strong, but to remain volatile due to exposure to domestic equities.

Source

Japan: Overseas risks & opportunities to remain critical for life insurers – Asia Insurance Review

Earnings growth among Japan's nine standalone traditional life insurers is expected to continue to stall in the financial year ending March 2019 (FY19), says Fitch Ratings. This is due mainly to persistently low bond yields in Japan, shrinking death-protection products because of Japan's contracting population, and reduced premium rates based on the updated standard mortality table from April 2018.

Meanwhile, the most profitable "third" (health) sector continues to grow steadily (up 4% yoy in FY18).
In its report, *Japanese Life Insurance Dashboard FY2018*, Fitch says that Japanese life insurance groups' global consolidated earnings will remain strong, supported by continuous expansion in their international insurance businesses after some major life insurers acquired medium-sized US and Australian life insurers to achieve earnings growth outside Japan and to diversify business risks.

Fitch considers that the major life insurers will continue to seek overseas growth opportunities. They are continually accumulating regulatory capital partly through hybrid debt issuance to cope with substantial overseas acquisitions, by taking advantage of extremely low bond yields worldwide and investors' appetite for yield.

Fitch makes the additional observations:

Foreign bonds boosted further: Fitch believes that Japanese lifers will continue to increase their investment allocation to foreign bonds – with some currency hedging – to seek higher yields. The major firms had increased their foreign securities exposure to 28% of their total invested portfolio by end-March 2018, from 27% a year earlier.

Currency-hedging costs in yen/US dollars have become more expensive, so Fitch sees most lifers as effectively raising their exposure to currency risk (increasing unhedged positions) and/or increasing their allocation to foreign-currency fixed-income assets such as euro-denominated bonds rather than US dollars. In addition, some insurers may be accumulating illiquid assets such as loans to infrastructure projects – again, in order to seek higher yield.

Interest rate risk remains: Fitch expects interest-rate risk to remain the primary risk as most Japanese life insurers are unlikely to lengthen asset duration aggressively (due to persistently low bond yields in Japan) despite the duration gap between assets and liabilities.

Capital adequacy strong: The life insurers' capital adequacy is likely to remain sufficient for their ratings, due to accumulated core capital and effective use of hybrid debt. The aggregate statutory solvency margin ratio had improved to 922% by end-March 2018.

Ratings Impact: Neutral. Fitch does not see life insurers' credit fundamentals worsening, despite continuously low Japanese fixed-income yields. This is due mainly to their stable profit stream from the seasoned and continuously growing in-force portfolio of "third" sector products.

Source

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